Optimal Health Associates

Patient Demographic Form

Please print neatly and fill in all blanks

Patient's Legal Name: _____
(first) (middle) (last)

Date of Birth: ____/____/____ Age: _____ Social Security No. _____-_____-_____

Circle One: Single Married Divorced Separated Other: _____

Patient's Address: _____
(street address) (city) (state) (zip code)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Email Address: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Name of the Primary Insurance Company: _____

Name of person who carries insurance: _____ Relationship to Patient: _____

Carriers DOB: ____/____/____ Carriers SSN: ____/____/____ Carriers Employer: _____

Secondary Insurance Company (if applicable) _____

Name of person who carries insurance: _____ Relationship to Patient: _____

Carriers DOB ____/____/____ Carriers SSN: ____/____/____ Carriers Employer: _____

Spouse's Name: _____ Phone: _____

Nearest relative not living with you: _____ Relationship: _____ PH: _____

If patient's a minor, please list both parents information:

Mother: _____ Employer: _____ Ph: _____

Father: _____ Employer: _____ PH: _____

I hereby authorize my insurance benefits to be paid directly to the facility and the physician. I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge and agree and received a copy of the HIPPA Privacy Notices.

_____

Signature Date

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Medications and Allergies

Please answer every question.

STAFF: All items on this page must be be entered MANUALLY.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

ALLERGIES

Please indicate if you have allergies to any of the following:

- I HAVE NO KNOWN ALLERGIES
- Sulfa Drugs
- Codeine / Codeine Derivatives
- Morphine Derivatives
- Erythromycin
- Penicillin
- Latex
- Adhesive Tape / Bandages
- Iodine
- Betadine
- Seasonal Allergies (Hay Fever)

Please list any additional allergies you have. If possible, include your reactions.
(e.g., hives, rash, itching, headaches, nausea, diarrhea, fainting, shock, shortness of breath, etc.)

Name	Reaction

MEDICATIONS

What medications are you currently taking?
(include prescriptions, over the counter medications, herbal supplements and vitamins.
e.g., Aspirin, Motrin, Vitamin E, St. John's Wort, etc.)

- I AM NOT CURRENTLY TAKING ANY MEDICATIONS (prescription or over the counter)

Name	Dosage	Frequency

Name	Dosage	Frequency

PHARMACY

Please list the pharmacy you would like us to use when calling in your prescriptions (if needed):

Pharmacy: _____

Location: _____

Noel R. Williams, M.D.
Benjamin J. Barenberg, M.D.
Abbey Ronck, PA-C
Christina Telcocci, PA-C
Shannan Carmouche, PA-C
Tricia Hall, PA-C
Amy Brooks, APRN
Bethany Cook, APRN

Authorization to Release Information via Phone/Family/Friends

Print your name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of this office regarding my healthcare, lab work, test results, treatments, appointments, prescriptions, etc... to be received at any of the phone numbers listed below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

DO not fill in numbers at which you do NOT wish to be contacted

Home Phone: _____ Cell: _____ Other: _____

I authorize the following individuals **(spouse, family member, and/or friend)** to call the office on my behalf to verify the status of appointments, treatment plan, medications, and/or account information. These individuals may also pick up prescriptions and/or samples that I have requested. **(Leave blank if you do not authorize any other individual to access your protected health information)**

Name: _____ Relation: _____ Phone Nbr: _____

Name: _____ Relation: _____ Phone Nbr: _____

Name: _____ Relation: _____ Phone Nbr: _____

Name: _____ Relation: _____ Phone Nbr: _____

Below is the pharmacy name and phone number that I will use for all prescriptions

Pharmacy Name: _____ Pharmacy Number: _____

I understand this authorization will remain in effect until I revoke the authorization *in writing.*

_____ _____

Patient Signature Date

Noel R. Williams, M.D
Benjamin J. Barenberg, M.D.
Abbey Ronck, PA-C
Christina Telcocci, PA-C
Shannan Carmouche, PA-C
Tricia Hall, PA-C
Amy Brooks, APRN
Bethany Cook, APRN

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physicians(s) in charge of the care of the patient to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR INSURANCE CLAIMS

I hereby authorize the physician(s) to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of the physician's charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, welfare funds, the Social Security Administration or it intermediaries or carriers. **I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AT ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release TPG, it agents and employees from liability in connection with the release of information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physicians(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit. I understand I am financially responsible for charges not covered by this assignment.

I understand a photocopy of this document is as valid as the original.

_____
Print Patient Name

_____ Date: _____
Patient's Signature

_____ Date: _____
Or Responsible Party Signature (parent of minor, etc...)

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Noel Williams and Dr. Benjamin Barenberg have an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____
Signature of Patient

_____
Signature of Parent or Guardian
(if applicable)

_____
Print Name of Patient

_____
Print Name of Parent or Guardian

Dated: _____

OPTIMAL
HEALTH

Attention Optimal Health Patients

Optimal Health has established a protocol for directing patient lab orders based on the patient insurance.

Our usual protocol is to perform labs at the Broadway location using our IN-HOUSE lab for insurances that Optimal Health is contracted with; including Blue Cross Blue Shield.
Since LabCorp will become the preferred in-network provider for Blue Cross Blue Shield on January 1st, 2017, Optimal Health will refer other outside testing to LabCorp.

If you have a laboratory preference for blood work and other gynecological tests, please acknowledge it below. We recommend verifying with your insurance plan benefits about your preferred lab provider.

I understand that each insurance plan has its own criteria for medical coverage and that I will be responsible for payment if testing is not fully covered, i.e., Cigna HMO, Cigna Open Access and strict Vitamin D criteria.

It is the patient's responsibility to inform the phlebotomist each time blood is drawn if they have a preferred Lab.

Please circle the laboratory of choice

NO PREFERENCE

IN-HOUSE LAB or IN-HOUSE LAB / LABCORP

LABCORP

DLO QUEST

Other: _____

Please sign below that you have read, understood, and agree to this policy.

Print Name: _____

Patient Signature: _____ Date: _____

Optimal Health Associates
CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT

Print Patient Name: _____ DOB: _____

The purpose of this agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management and/or anxiety management. This is to help both the patient and their provider comply with the law regarding controlled medications. Please read this contract thoroughly, as it is a condition of your continued treatment. Your signature will be required.

The use of opioids, benzodiazepines and stimulants may cause addiction, and is only one part of a complete treatment plan.

I agree to the following:

1. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take any medicine not prescribed to me.
2. Forging or altering a narcotic prescription, or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated, and I will be reported to law enforcement authorities.
3. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
4. I will not increase my medicine until I speak with my doctor or nurse.
5. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
6. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
7. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
8. I agree to come to the office for a pill count at any time if asked by my doctor.
9. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
10. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test, and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit, and again randomly through the course of my treatment.
11. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
12. I have been informed by my physician about narcotic effects, including the normal physiological effect of tolerance (where I might need to take more medication to obtain the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior), which is very rare in patients with genuine pain.
13. I understand that narcotics can adversely affect my judgement in making business decisions, and in operating equipment such as an automobile.
14. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control and limiting my use of unhealthy substances like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.
15. I understand that there will be a trial period for this medication regime. Within this period, my case will be reviewed. If there is no evidence that I am improving, or if progress is not being made to improve my function and quality of life, my medication regime will be tapered and my care will be referred back to my primary care physician.

16. Non-payment of services rendered may result in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment, I will not receive a refill on my medications.

Refills

- I understand that refills of narcotic medication will be given only during my regularly scheduled appointment, or once monthly by telephone if the current prescription has been correctly used. If the medication requires a written prescription, I must call 3 business days in advance. If the medication does not require a written prescription, I will call my pharmacy 3 business days in advance and have them fax the request to the office.
- I understand that refills will be made only during regular office hours – Monday through Thursday, 8:30AM – 4:30PM. No refills will be available on nights, holidays or weekends. Advance notice of 3 days is required.
- I must keep track of my medications. No early or emergency refills may be made. Prescriptions must be filled before expiration. In the event the prescription has expired, the prescription must be returned to this office before the new prescription will be written.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name and phone number of my pharmacy is _____.

Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they obtain narcotics form this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if narcotics have been obtained from another physician.

Prescriptions form Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to see or accept medications form other providers without my doctor's permission.

Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way, and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

I have talked about this agreement with my doctor and I understand the above rules.

Patient's signature _____ Date _____

Physician's signature _____

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Direction of Feed

Women's Preventive Health

Please answer every question

Handwritten items must be entered MANUALLY. Do not fold this form.

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please write the ending date of your last menstrual period: _____

Have you ever had any of the listed colon cancer screenings?	yes	no	do not know	If yes, date:
Colonoscopy	○	○	○	
Sigmoidoscopy	○	○	○	
Barium enema	○	○	○	
Stool hemoccult (test for blood in stool)	○	○	○	

Have you been immunized against the following?	yes	no	do not know	If yes, date:
Human papillomaviruses / HPV / Guardasil	○	○	○	
Influenza / Flu (within the past year)	○	○	○	
Measles, Mumps & Rubella / MMR	○	○	○	
Pneumonia	○	○	○	
Shingles / Zostavax	○	○	○	
Tetanus / Diphtheria (within last 10 years)	○	○	○	
Chickenpox / Varicella	○	○	○	

Have you had the following?	yes	no	n/a	If yes, date:
Test for chlamydia (age 24 and under)	○	○	○	
Pap smear within the past 2 years (age 18+)	○	○	○	
Have you had an abnormal pap smear?	○	○	○	
Mammogram within the past 2 years (age 40+)	○	○	○	
Bone density study / DEXA scan within the past 2 years (age 50+)	○	○	○	

	yes	no	If yes, date:
Are you pregnant or possibly pregnant?	○	○	
Do you perform monthly self-breast exams?	○	○	
Do you take a daily calcium supplement?	○	○	
Have you had your cholesterol checked in the last five years?	○	○	

Age at onset of menstruation: n/a ○ <8 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16 ○ 17 ○ 18 ○ 19 ○ 20 ○ 21+ ○

Age at onset of menopause: n/a ○ <42 ○ 42 ○ 43 ○ 44 ○ 45 ○ 46 ○ 47 ○ 48 ○ 49 ○ 50 ○ 51 ○ 52 ○ 53 ○ 54 ○ 55+ ○

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Direction of Feed

Women's History

Please answer every question

Handwritten items must be entered MANUALLY.
Do not fold this form.

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

SOCIAL HISTORY

TOBACCO USE

What is your smoking status? current (every day) ○ current (some days) ○ in the past ○ never ○

How many packs per day do you (or did you) smoke? less than 1 ○ 1-2 ○ more than 2 ○

How many years have you (or did you) smoke? 5 or less ○ 6-10 ○ more than 10 ○

Do you use other tobacco products? currently ○ in the past ○ never ○

Are you exposed to passive (secondhand) smoke? yes ○ no ○

ALCOHOL USE

Do you consume alcohol? (If you answer 'never', skip ahead to DRUG USE section.) never ○ in the past ○ currently ○

Type(s): wine ○ beer ○ liquor ○

How often do you drink?
Number of times: 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○
Per: never ○ week ○ month ○ year ○

How often do you have 4 or more drinks per occasion? never ○ occasionally ○ rarely ○ frequently ○

DRUG USE

Do you use street drugs? never ○ prefer to discuss with physician ○ in the past ○ currently ○

Type(s): prescriptions not prescribed to you ○ marijuana ○ cocaine ○ meth ○ speed ○ crack ○ PCP ○ LSD ○ heroin ○

RISK FACTORS

Please answer yes or no if you or your partner have had any of the following: IV drug use, more than one sexual partner, unprotected sexual contact, contact with contaminated injection equipment, multiple blood transfusions, HIV or Hepatitis B. yes ○ no ○

CAFFEINE

Type(s): coffee ○ tea ○ soft drinks ○

Drink(s) per day: never ○ occasionally ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

EXERCISE

Type(s): bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○

Times per week: never ○ occasionally ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

OTHER

How often do you wear a seatbelt? always ○ almost always ○ occasionally ○ never ○

Sun exposure: rarely ○ occasionally ○ frequently ○

Do you feel safe at home? yes ○ no ○

In the past year, have you been hit, punched, kicked or slapped by anyone? yes ○ no ○

SURGICAL HISTORY

Please indicate if you have a history of the following. Mark all that apply.

○ I HAVE HAD NO SURGERIES

- ○ Appendectomy
- ○ Bladder
- ○ Bowel
- ○ Breast Biopsy / Lumpectomy
- ○ Cervical
- ○ Colon
- ○ Cosmetic
- ○ Gallbladder Removal
- ○ Hysterectomy (Abdominal)
- ○ Hysterectomy (Vaginal)
- ○ Incontinence
- ○ Laparoscopy
- ○ Mastectomy
- ○ Ovary Removal
- ○ Rectal
- ○ Tonsillectomy
- ○ Tubal Ligation
- ○ Other (please specify): _____

Women's History

Please answer every question

YOUR MEDICAL HISTORY

Please mark all items that you have had:

Patient's name: _____

- ◯ Anemia
- ◯ Anesthesia Complications
- ◯ Anxiety
- ◯ Asthma
- ◯ Autoimmune Disorder
- ◯ Bladder Infections
- ◯ Bleeding Between Periods
- ◯ Bleeding Disorder (Non-Menstrual)
- ◯ Blood Clots
- ◯ Blood Transfusions
- ◯ Bothersome Loss of Urine
- ◯ Cancer (Breast)
- ◯ Cancer (Cervical)
- ◯ Cancer (Colon)
- ◯ Cancer (Lung)
- ◯ Cancer (Ovarian)
- ◯ Cancer (Uterine)
- ◯ Chlamydia
- ◯ Depression
- ◯ DES Exposure (Mark if your mother took DES during pregnancy.)
- ◯ Diabetes
- ◯ Emotional Neglect / Abuse
- ◯ Endometriosis
- ◯ Epilepsy / Seizures
- ◯ Gallbladder Disorder
- ◯ Gastrointestinal Disorder
- ◯ Genital Warts
- ◯ Gonorrhea
- ◯ Heart Disease
- ◯ Hepatitis
- ◯ Herpes
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ History of Taking Antibiotics (For Dental Work)
- ◯ HIV Exposure
- ◯ HPV (Human PapillomaVirus)
- ◯ Infertility
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Major Accident
- ◯ Migraine Headaches
- ◯ Mitral Valve Prolapse
- ◯ Neurologic Disorder
- ◯ Non-Surgical Hospitalization
- ◯ Osteoporosis / Osteopenia
- ◯ Ovarian Cysts
- ◯ Pain / Bleeding During Intercourse
- ◯ Physical Neglect / Abuse
- ◯ PMS
- ◯ Psychiatric Care / Hospitalization
- ◯ Rheumatic Fever
- ◯ RH Sensitized
- ◯ Severe Cramping
- ◯ Severe Pain During Period
- ◯ Sexual Difficulty
- ◯ Sickle Cell Trait / Disease
- ◯ Stroke / CVA of the Brain
- ◯ Syphilis
- ◯ Thyroid Disorder
- ◯ Trichomonas
- ◯ Tumors
- ◯ Urinary Problems
- ◯ Uterine Abnormality
- ◯ Uterine Fibroids
- ◯ Vaginal Discharge
- ◯ Vaginal Infection
- ◯ Varicose Veins
- ◯ Weight Disorder
- ◯ **Other** (please specify): _____

◯ **NO SIGNIFICANT MEDICAL HISTORY**

MENSTRUAL HISTORY

Menstrual period:	n/a ◯	light to moderate flow ◯	
	excessive cramping ◯	excessive flow ◯	
Length of flow (on average):	0-4 days ◯	5-7 days ◯	8 or more days ◯
Cycle regularity (from 1st day of period to start of next period):	regular ◯	irregular ◯	don't have periods ◯

Current contraception (mark all that apply):

- ◯ abstinence
- ◯ condom
- ◯ Depo-Provera®
- ◯ foam
- ◯ hysterectomy
- ◯ IUD
- ◯ patch
- ◯ pill
- ◯ rhythm
- ◯ ring
- ◯ tubal sterilization
- ◯ vasectomy
- ◯ other
- ◯ NONE

Prior contraception (mark all that apply):

- ◯ abstinence
- ◯ condom
- ◯ Depo-Provera®
- ◯ foam
- ◯ hysterectomy
- ◯ IUD
- ◯ patch
- ◯ pill
- ◯ rhythm
- ◯ ring
- ◯ tubal sterilization
- ◯ vasectomy
- ◯ other
- ◯ NONE

SEXUAL HISTORY

Have you ever had sex?	yes ◯	no ◯
If yes, did you begin having sex before the age of 18?	yes ◯	no ◯
Are you currently sexually active?	yes ◯	no ◯
Are you planning a pregnancy this year?	yes ◯	no ◯

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Direction of Feed

Women's History

Please answer every question

Handwritten items must be entered MANUALLY. Do not fold this form.

Patient's name: _____

PREGNANCY HISTORY

	0	1	2	3	4	5	6	7	8	9	10+
Number of pregnancies (include current)	○	○	○	○	○	○	○	○	○	○	○
Number of live births	○	○	○	○	○	○	○	○	○	○	○
Number of stillbirths	○	○	○	○	○	○	○	○	○	○	○
Number of vaginal deliveries	○	○	○	○	○	○	○	○	○	○	○
Number of cesarean sections	○	○	○	○	○	○	○	○	○	○	○
Number of miscarriages	○	○	○	○	○	○	○	○	○	○	○
Number of abortions	○	○	○	○	○	○	○	○	○	○	○
Number of ectopics (tubal pregnancy)	○	○	○	○	○	○	○	○	○	○	○

Have you had any complications?

○ bleeding ○ high blood pressure ○ breech ○ premature labor ○ other
○ diabetes ○ pre-term delivery ○ pre-term rupture of membrane(s) ○ NONE

FAMILY MEDICAL HISTORY

Please indicate which family members have had these illnesses:

○ FAMILY HISTORY UNKNOWN ○ NO SIGNIFICANT FAMILY MEDICAL HISTORY

	Mother	Father	Sister	Brother	Daughter	Son
Breast Cancer	○	○	○	○	○	○
Lung Cancer	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Ovarian Cancer	○		○		○	
Uterine Cancer	○		○		○	
Other Cancer	○	○	○	○	○	○
PMS	○		○		○	
Endometriosis	○		○		○	
Cesarean Section	○		○		○	
Bleeding Disorder	○	○	○	○	○	○
Sickle Cell Disease	○	○	○	○	○	○
Blood Clots	○	○	○	○	○	○
Varicose Veins	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
Heart Attack	○	○	○	○	○	○
Thyroid Disease	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Weight Disorders	○	○	○	○	○	○
Osteoporosis / Osteopenia	○	○	○	○	○	○
Tuberculosis	○	○	○	○	○	○
Respiratory Disease	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○
Migraine Headaches	○	○	○	○	○	○
Seizures / Epilepsy	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Depression / Anxiety	○	○	○	○	○	○
Psychiatric Care / Hospitalization	○	○	○	○	○	○

Other (please specify): _____

Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Review of Systems

Please answer every question

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Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please mark only the symptoms you CURRENTLY are experiencing.

Mark all that apply ---- if no symptoms, please mark "NONE"

General
- fever ○
- fatigue ○
- weight loss ○
- weight gain ○
- persistent infections ○
- NONE ○

Eyes
- visual disturbances ○
- glasses/contacts ○
- NONE ○

Ear, Nose, and Throat
- hearing loss ○
- seasonal allergies ○
- sinus pain ○
- oral ulcers ○
- NONE ○

Cardiovascular
- chest pain ○
- shortness of breath ○
- palpitations ○
- swelling hands/feet ○
- difficulty breathing on exertions ○
- NONE ○

Respiratory
- difficulty breathing ○
- wheezing ○
- chronic cough ○
- coughing blood ○
- NONE ○

Breast
- mass/lump ○
- breast pain ○
- nipple discharge ○
- NONE ○

Gastrointestinal
- nausea ○
- vomiting ○
- change in bowel habits ○
- constipation ○
- chronic diarrhea ○
- abdominal pain ○
- bloody stool ○
- hemorrhoids ○
- excessive gas ○
- indigestion ○
- NONE ○

Female Genitourinary (Women Only)
- urinary frequency ○
- urinary urgency ○
- excessive urination at night ○
- vaginal dryness ○
- vaginal discharge ○
- vaginal itch or burning ○
- painful intercourse ○
- painful urination ○
- painful menstruation ○
- menstrual irregularities ○
- urine leakage ○
- pelvic pain ○
- blood in urine ○
- NONE ○

Male Genitourinary (Men Only)
- painful urination ○
- change in urinary stream ○
- excessive urination at night ○
- urinary frequency ○
- urinary urgency ○
- impotence ○
- urethral discharge ○
- testicular mass ○
- testicular pain ○
- penile lesions ○
- blood in urine ○
- urine leakage ○
- NONE ○

Musculoskeletal
- joint pain ○
- muscle pain ○
- muscle weakness ○
- NONE ○

Skin
- dry skin ○
- change in wart or mole ○
- rash ○
- hives ○
- new sore/lesion ○
- skin ulcer ○
- NONE ○

Neurologic
- fainting ○
- decreased memory ○
- numbness ○
- trouble walking ○
- seizures ○
- headaches ○
- NONE ○

Psychiatric
- anxiety ○
- change in sleep pattern ○
- frequent crying ○
- depression ○
- fearful ○
- NONE ○

Endocrine
- hair changes ○
- heat intolerance ○
- cold intolerance ○
- hot flashes ○
- NONE ○

Heme/Lymphatic
- easy bruising ○
- excessive bleeding ○
- gland problems ○
- NONE ○