

REVIEW OF SYSTEMS: Circle only the ones you NOW have or have had RECENTLY

General	Skin	Head	Eyes	Ears	Nose	Mouth	Throat
Weakness Fatigue Fever Chills Night Sweats Fainting	Color Changes Nail Changes Hair Changes Moles/Warts Rashes Itching Sores Dryness	Headaches Injuries Bumps Last Eye Exam ____/____/____ Glasses Contacts Cataracts	Blurred Vision Glaucoma Redness Itching Burning Swelling Pain Dryness Tearing	Hard of Hearing Deafness Ringing Discharge Earache Itching Loss of Balance Dizziness Room Spins	Decreased Smell Bleeding Pain Discharge Obstruction Post Nasal Drip Deviated Septum Runny Nose Sinus Congestion	Bleeding Gums Sores Dental Problems Pain Bad Breath Loss of Taste Dry Mouth Ulcers Blisters	Soreness Bad Tonsils Hoarseness Pain Trouble Swallowing Recurrent Infection Voice Problems
Neck	Breasts	Lungs	Heart	Blood	Gastrointestinal		
Enlargement Stiffness Soreness Lumps Masses	Discharge Lumps Pain/Tender Bleeding Nipple Changes Skin Changes	Cough Phlegm Blood Short of Breath Wheezing Pain Congestion Inhalant Exposure	Murmur Palpitations Rapid Heartbeat Swollen Extremities Cold Extremities Chest Pain Pressure Varicose Veins Blood Clots Blue Extremities	Anemia Low Blood Iron Easy Bruising Easy Bleeding Swollen Nodes Painful Nodes Sugar in Blood Red Spots	Abdominal Pain Nausea Vomiting Bloating Belching Heartburn Indigestion Irregular Bowel Habits Constipation	Diarrhea Gas/Flatulence Hemorrhoid Hernias Poor Appetite Food Intolerance Blood Stools Black Stools	
Genitourinary			Gynecological				
Urgency Incontinence Staining Back Pain Frequent Voiding Stones Burning Blood Urine	Small Stream Discharge Sores Impotence Dribbling Cloudy Urine Bed Wetting Urine Color: _____	Spotting Between Periods Menstrual Cramping Spotting After Periods Discharge Itching Painful Intercourse Irregular Periods Hot Flashes Pain Between Periods	Contraception (Type) _____ Age of First Period _____ Age of Menopause _____ Duration of Cycle _____ Duration of Flow _____ No. of Pregnancies _____ No. of Births _____ No. of Miscarriages/Abortions _____ Nausea of Pregnancy _____	Menstrual Flow: Heavy Moderate Light Last Period: _____ Last Pap: _____ Last Mammo: _____			
Musculoskeletal	Neurological		Psychiatry			Endocrine	
Muscle Pain Muscle Weakness Muscle Cramps Joint Stiffness Joint Pain Joint swelling	Injuries Tenderness Curvature of Spine Back Pain Hot Joints Joint Deformities	Seizures Vertigo Dizziness Tingling Memory Loss In Coordination Loss of Facial Expressions	Weak Grip Paralysis Difficulty of Speech Hand Trembling Numbness Loss of Sensation	Hyperventilation Insecurity Depression Troubled Sleep Irritable Anxiousness Undecidedness Timid	Hallucinations Loss of Memory Alcoholism Drug Addiction Drug Dependency Suicidal Thoughts Extreme Worry Sexual Problems	Weight Loss Weight Gain Hoarseness Heat Intolerance Cold intolerance Breast Changes Hair Changes Extreme Thirst Voice Changes	
Immunizations/Vaccinations	Blood Type	Blood Transfusions		Last Chest x-ray	Allergies		
DPT Mumps Smallpox Typhoid Tetanus	German Measles Red Measles Influenza Polio MMR	A+ B+ AB+ O+ Other: _____	A- B- AB- O- _____	No. of Transfusions: _____ Date(s) _____ Reasons _____	Date ____/____/____ Normal/Abnormal Last Tb Skin Test Date _____ Positive/Negative	_____ _____ _____ _____	

PAST MEDICAL HISTORY: Circle only the ones you have had in the PAST.

Past general state of Health: **Excellent** **Good** **Fair** **Poor**

Hay Fever	Tonsillitis	Stroke	Diabetes	Mental Illness	Other: _____
Mumps	Sinusitis	Ulcers	Syphilis	Alcoholism	
Measles	Goiter	Jaundice	Gonorrhea	Depression	_____
Rheumatic Fever	Breast Trouble	Gallstones	Hernia	Nervous Breakdown	
Allergies	Asthma	Liver Trouble	Sexual Problems	C.M.V.	_____
Anemia	Bronchitis	Hepatitis	Prostate Problems	E.B.V.	
Cancer	Pleurisy	Parasites	Hemorrhoids	Candidiasis	_____
Tumor	Pneumonia	Dysentery	Arthritis	Strep Throat	
Blood Disease	Tuberculosis	Colitis	Gout	Hyperactivity	
Leukemia	Heart Trouble	Polyps/Fissures	Migraines	Whooping Cough	
Skin Acne/Boils	Varicose Veins	Kidney Infections	Epilepsy	Chicken Pox	
Cataracts Phlebitis	Kidney Stones	Paralysis	Styes	Hypertension	
Bladder Trouble	Polio				

Family History

Blood Relatives Only	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

Children (Names and Ages): _____

Social History

Current Weight _____ Usual Weight _____ Maximum Weight _____ Minimum Weight _____

Mental Work	Physical Work	Exercise	Smoking	Alcohol			
Heavy Moderate Light No. Hours per Day _____	Heavy Moderate Light No. Hours per Day _____	Heavy Moderate Light Types _____ No. hours per Week _____	Current Previous No. Packs per Day _____ No. of Years _____ Others _____	Beer Amount/week _____ Liquor Amount/week _____ Wine Amount/week _____ No. of Years _____			
Caffeine (Coffee, Tea, Cola) Cups per Day _____ No. of Years _____ Aspirins No. per Day _____ No. of Years _____ Others _____	Please write in boxes what you generally eat <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">Breakfast</td> <td style="width: 33%; border: none;">Lunch</td> <td style="width: 33%; border: none;">Dinner</td> </tr> </table>			Breakfast	Lunch	Dinner	Drugs No. Doses per Week ___ Vitamins ___ Laxatives ___ Antacids ___ Diet Pills ___ Pain Pills ___ Water Pills ___ Nerve Pills ___ Potassium ___ Nutrasweet ___ Saccharin Others: _____ _____ _____
Breakfast	Lunch	Dinner					

OUR OFFICE FINANCIAL POLICY

We are pleased to serve your health care needs and are committed to providing you with the best possible care. The medical staff wants to ensure that your visit is educational, and medically beneficial.

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or financial policy or your responsibility.

- All patients must sign in and complete our "Identification Data Form" before seeing the doctor. We will also have you sign your chart on each visit.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- We accept checks, Visa, Mastercard, Discover, American Express, or cash.

MISSED APPOINTMENTS

We do require 24 hours cancellation notice. It is the policy of our office to charge for missed appointments. Please help us serve you better by keeping scheduled appointments.

REGARDING INSURANCE

It is the policy of this office that all office visits will be paid in full at the time of the visit, unless prior arrangements are made. Insurance forms are not accepted as payment for office visits. **WE DO NOT ACCEPT INSURANCE.** We are not on any insurance list. We will provide you with a superbill so that you may submit to your Insurance if you are eligible for reimbursement. **INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.** We are not party to this contract. We will not become involved in disputes between your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account.

MEDICARE/MEDICAID/CHAMPS/WORKER'S COMPENSATION

We have been notified by Medicare and Medicaid, that services provided by our office are not covered. They do not cover homeopathy, acupuncture, chelation therapy or any other alternative treatment. We will provide you with a letter from Medicare to use as an Explanation of Benefits so you may submit to your secondary insurance if needed.

I have read and completely understand the above policy. I agree to be personally responsible for any professional services rendered.

SIGNATURE _____ DATE _____