**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Social Security Number:** \_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_

##### VASCULAR NEW PATIENT REGISTRATION

**Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name First MI**

### Date of Birth: \_\_\_\_\_\_\_\_\_\_ Male Female Marital Status: S M W D Age \_\_\_\_\_

#

**Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you Hispanic? \_\_Yes \_\_No Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# State/zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_Cell Phone #: (\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Driver’s License#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_\_\_

Is this work-related? Yes No If yes, date of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #: \_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### PATIENT’S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance is through: Patient Spouse Parent Other DOB of Insured:\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance is through: Patient Spouse Parent Other DOB of Insured:\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a Minor, are parents Married Divorced? Custodial Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­

Custodial Parent’s Home Phone: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_\_

Custodial Parent’s SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### PHYSICIAN INFORMATION

Referring Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (\_\_\_\_\_) \_\_\_\_\_\_ -- \_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize Soleil Surgical LLC to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to Soleil Surgical LLC immediately upon receipt.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent or Legal Guardian Relationship to Patient Date

A Medical Corporation

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

##### HIPAA / NOTICE OF PRIVACY PRACTICES (Page 1)

The law permits us to use or disclose your health information to the following:

* Another specialist or physician who is involved in your care.
* Your insurance company, for the purpose of obtaining payment for our services.
* Our staff, for the purpose of entering your information into our computerized system
* Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
* If this practice is sold, your health information will become the property of the new owner.
* We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients’ protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

* You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
* You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
* You have the right to request in writing to inspect and/or receive a copy of your health information. \* Our office may charge a reasonable fee to cover copying and mailing of these records to you.
* You have the right to request an alternate means or location to receive communications regarding your health information. \*
* You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

\* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

##### HIPAA / NOTICE OF PRIVACY PRACTIVES (Page 2)

* We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

[ ]  **OK to Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  OK to ALL family members: Please list names of family members:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  OK to Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  OK to leave health information on answering machine or voice mail**

**[ ]  DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).**

**[ ]  DO NOT RELEASE TO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office manager.

# ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_

If person signing is not patient please provide:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### BILLING AND FINANCIAL POLICY (Page 1)

The following sets forth the policies of Soleil Surgical LLC. Please review this information and sign where indicated below

* I understand that it is my responsibility to furnish Soleil Surgical LLC with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.
* I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.
* I understand that a cancellation fee of $50.00 may be billed directly to myself if a 48-hour cancellation notice is not provided to our office. Specialty Ultrasound Appointments will have a $50.00 cancellation fee per test scheduled. In office procedure will have a $150.00 cancellation fee.
* I understand that a surgery cancellation fee of $150.00 may be billed directly to myself if a surgery is cancelled. Our office will allow one cancellation with no fee charged but if a surgery is cancelled by the patient or patient’s family again, this fee will be assessed.
* It is the responsibility of each patient to understand their insurance policy and its requirements for specialty office visits. It is the patient’s responsibility to make sure there is a valid referral on file for their appointment before coming to the office. If the day of the appointment there is no valid referral on file, the appointment will be rescheduled. Soleil Surgical LLC and/or its representatives will make every effort to assist you, but will not be held accountable if there is no referral on file for your visit.
* I understand that there is a $25.00 fee (per form) to complete disability paperwork associated with my care.

##### BILLING AND FINANCIAL POLICY (Page 2)

* I understand that the office will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that a surgery co-pay may be collected upfront and applied to those fees. I further understand that ANY FEES I AM QUOTED ARE ESTIMATED based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.
* I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as “Final Notice” and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.
* I understand that the office will obtain the necessary authorizations prior to surgery. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.
* I understand that the office may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of Soleil Surgical LLC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
Legal Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Patient

|  |
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| **PATIENT HISTORY FORM** |

 **DATE \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ REFERRING DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PRIMARY CARE DOCTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REASON FOR VISIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **MEDICATIONS** |  |
| **Please list all current medications, including vitamins:** |
| **Name of medication** | **Dose** | **Frequency** |  |
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| **HISTORY OF PRESENT ILLNESS** |  | **ALLERGIES** |
|  Anorexia | [ ]  Yes [ ]  No | **Please list all drug allergies:** |
| Fatigue | [ ]  Yes [ ]  No |  |  | **Drug** | **Reaction** |
| Fever | [ ]  Yes [ ]  No |  |  |  |
| Joint Pain | [ ]  Yes [ ]  No |  |  |  |
| Muscle Pain | [ ]  Yes [ ]  No |  |  |  |
| Neck Pain | [ ]  Yes [ ]  No |  |  |  |
| Night Sweats | [ ]  Yes [ ]  No |  |  |  |
| Recent Weight Gain | [ ]  Yes [ ]  No |  |  |  |
| Recent Weight Loss | [ ]  Yes [ ]  No  |  |  |  |
| Edema | [ ]  Yes [ ]  No |  |  |  |

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **PAST MEDICAL HISTORY** |
| **Please check whether you have or have had any of the following conditions:** |
| Diabetes Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | High cholesterol | [ ]  Yes [ ]  No |
| Blood Clots/DVT | [ ]  Yes [ ]  No | Problems with Anesthesia | [ ]  Yes [ ]  No |
| High blood pressure/Hypertension | [ ]  Yes [ ]  No | COPD/emphysema | [ ]  Yes [ ]  No |
| Previous Heart Attack | [ ]  Yes [ ]  No | Asthma | [ ]  Yes [ ]  No |
| Congestive heart failure | [ ]  Yes [ ]  No | Stroke | [ ]  Yes [ ]  No |
| Chronic Kidney Disease Stage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | Varicose Veins | [ ]  Yes [ ]  No |
| Atrial fibrillation | [ ]  Yes [ ]  No | Arthritis | [ ]  Yes [ ]  No |
| Cancer Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | Hepatitis BHepatitis CHIV | [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No |
| **Others:** |

|  |
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| **PAST SURGICAL AND VASCULAR HISTORY** |
| **Please list all prior surgeries (include angioplasty with where on body, stents or bypass):** |
| **Surgery** | **Year** | **Surgery** | **Year** |
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| **PAST HOSPITALIZATIONS** |
| **Please list all hospitalizations within the last 5 years:** |
| **Reason** | **Year** | **Reason** | **Year** |
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**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **FAMILY HISTORY** |
| **Please answer the following questions about your family members:** |
| **Father** | **[ ]**  Alive **[ ]**  Deceased |  |  |
| **[ ]**  Abdominal Aortic Aneurysm **[ ]**  Heart Disease **[ ]**  Kidney Disease **[ ]**  Blood ClotsOther Medical Problems: |
| **Mother** | **[ ]**  Alive **[ ]**  Deceased |  |  |
| **[ ]**  Abdominal Aortic Aneurysm **[ ]**  Heart Disease **[ ]**  Kidney Disease **[ ]**  Blood ClotsOther Medical Problems: |
| **Sister** | **[ ]**  Not Applicable **[ ]**  Alive **[ ]**  Deceased |
| **[ ]**  Abdominal Aortic Aneurysm **[ ]**  Heart Disease **[ ]**  Kidney Disease **[ ]**  Blood ClotsOther Medical Problems: |
| **Brother** | **[ ]**  Not Applicable **[ ]**  Alive **[ ]**  Deceased**[ ]**  Abdominal Aortic Aneurysm **[ ]**  Heart Disease **[ ]**  Kidney Disease **[ ]**  Blood ClotsOther Medical Problems: |
| **Other Family** | Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.) |

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| **SOCIAL HISTORY** |
| **Drinks Alcohol** | Do you drink alcohol? **[ ]** Yes **[ ]** No If yes how often? Daily - Weekly – Monthly – Socially - Rarely |
| **[ ]** Beer **[ ]** Wine **[ ]** Liquor Amount? When was your last drink? |
| **Tobacco Use** | Do you smoke? **[ ]** Yes **[ ]** No If yes, how many packs per day? |
| How many years did you smoke? | What year did you quit? |
| **Drug Use** | Do you currently use recreational drugs? **[ ]** Yes **[ ]** No Have you in the past? **[ ]** Yes **[ ]** NoHave you ever used intravenous drugs? **[ ]** Yes **[ ]** No  |
| **Employment****Social History** | Occupation (past or present): |
| Marital Status, please circle one: Single , Married , Widowed , DivorcedWho Lives in your home with you? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Do you have children? \_\_\_\_\_\_\_ If so how many \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Miscellaneous** | Have you ever received a blood transfusion? **[ ]** Yes **[ ]** No  |

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **REVIEW OF SYSTEMS** |
| **Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:** |
| **Allergy/Immunology** |  | **Cardiovascular** |  |
|  Itching | [ ]  Yes [ ]  No |  Chest pain at rest | [ ]  Yes [ ]  No |
|  Rash | [ ]  Yes [ ]  No |  Difficulty lying flat | [ ]  Yes [ ]  No |
|  Unusual reaction to medicine | [ ]  Yes [ ]  No |  Heart problems | [ ]  Yes [ ]  No |
|  Wheezing [ ]  Yes [ ]  No |  High Blood Pressure [ ]  Yes [ ]  No Palpitations [ ]  Yes [ ]  No |
|  |  |
| **ENT**  |  | **Hematology** |  |
|  Swollen Glands | [ ]  Yes [ ]  No |  Anemia | [ ]  Yes [ ]  No |
|  Snoring | [ ]  Yes [ ]  No |  Easy bruising | [ ]  Yes [ ]  No |
|  Sore Throat | [ ]  Yes [ ]  No |  Recent Transfusion | [ ]  Yes [ ]  No |
|  Difficulty Swallowing | [ ]  Yes [ ]  No |  Bleeding problems [ ]  Yes [ ]  No |
| **Endocrine** |  | **Musculoskeletal** |  |
|  Heat Intolerance | [ ]  Yes [ ]  No |  Arthritis | [ ]  Yes [ ]  No |
|  Cold Intolerance Thyroid Problems  Weakness  | [ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No |  Leg Cramps Joint stiffness Trauma to arm Trauma to knee Trauma to ankle | [ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  Nos |
| **Respiratory** |  |  |
|  Chest pain | [ ]  Yes [ ]  No |  |  |
|  Shortness of Breath | [ ]  Yes [ ]  No |  |  |
|  Cough | [ ]  Yes [ ]  No |  |  |
|  Asthma | [ ]  Yes [ ]  No |  |

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| **REVIEW OF SYSTEMS** |
| **Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:** |
| **Peripheral Vascular** |  | **Skin** |  |
|  Ulceration of feet | [ ]  Yes [ ]  No |  Dry Skin | [ ]  Yes [ ]  No |
|  Painful extremities Absent pulses in feet Absent pulses in hands  | [ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No |  Discoloration Masses Scaly lesion of skin/scalp  Sun sensitivity Keloid formation | [ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No |
| **Podiatric**  |  | **Neurology** |  |
|  Difficulty walking | [ ]  Yes [ ]  No |  Headaches | [ ]  Yes [ ]  No |
|  Foot numbness | [ ]  Yes [ ]  No |  Loss of use of extremity | [ ]  Yes [ ]  No |
|  Wound oozing | [ ]  Yes [ ]  No |  Stroke | [ ]  Yes [ ]  No |
|  Burning Foot pain | [ ]  Yes [ ]  No[ ]  Yes [ ]  No |  Seizures [ ]  Yes [ ]  No Tingling/numbness [ ]  Yes [ ]  No Memory loss [ ]  Yes [ ]  No Loss of strength [ ]  Yes [ ]  No |
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