Fresno Women's Medical Group

Patient Registration Sheet

Last Name: _____ **First Name:** _____ **Middle:** _____

Preferred Name: _____ **Maiden Name:** _____ **Pharmacy:** _____ **Location:** _____

DOB: _____ **Sex:** _____ **SSN:** _____ **Marital Status:** _____ **Driver's License:** _____

Mailings Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____ **Preferred:** _____

Email: _____ **Employed By:** _____ **Phone:** _____

Employer Address: _____ **Occupation:** _____ **Primary Care Dr:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____ **DOB:** _____

Federal regulations now require that we collect the following demographic information.

Please check one of the options from each category.

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African America ☐ Decline to answer
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other Race

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to answer

Religious Preference: ☐ Buddhist ☐ Catholic ☐ Hindu ☐ Islam ☐ Jehovah's Witness
☐ Jewish ☐ Mormon ☐ N/A ☐ Other_____ ☐ Protestant

Insurance Information (Please provide a current copy of your insurance card).

Primary Insurance Carrier: _____ Self/Spouse/Parent **through** Individual or Employer

Policy Holder Name: _____ **DOB:** _____ **SSN:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Secondary Insurance Carrier: _____ Self/Spouse/Parent **through** Individual or Employer

Policy Holder Name: _____ **DOB:** _____ **SSN:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

I understand that I will be responsible for any co-insurance, deductible, or spend down not covered by my insurance. If any balance is not paid when due I Understand that I will be responsible for the balance. I also understand that if the unpaid account is referred to an outside agency, I am responsible to pay all costs of collection including attorney fees. I hereby authorize the release of information to my insurance carrier or its intermediaries for all covered services rendered by Fresno Women's Medical Group.

_____	_____	_____	_____
Patient Signature	**Print name if other than patient**	**Relationship to patient**	**Today's Date**

Fresno Women's Medical Group

OFFICE POLICY

Fresno Women's Medical Group, Inc. (FWMG), offers women's healthcare services specializing in obstetrics and gynecology. We want to work with you to help you achieve optimal health.

Facilities. FWMG physicians provide obstetric and emergency services only at Clovis Community Hospital. If you present to any other facility with emergency needs, we will be unable to attend you. Our surgical patients may be scheduled at Fresno Surgical Hospital, Clovis Community Hospital or Saint Agnes Medical Center. Please be advised that FWMG, Inc. has an ownership interest in Fresno Surgical Hospital.

On-Call Physician. A qualified physician is on-call for our group at all times. We cannot guarantee a specific physician for on-call services.

Specialists. We are specialists in obstetrics and gynecology and our practice also includes two family practice providers. It is important that you establish a relationship with a primary care physician.

Healthy Choices. We want to work with you to help you make healthy choices. You have the right to decline any medical therapies or evaluations which we might recommend. We want to help ensure that our pregnant patients will deliver healthy babies. For this reason we may on occasion, order toxicology studies (drug screens) on our pregnant patients.

Phone Calls. We cannot provide adequate medical care over the telephone or fax. Our physicians and nurse practitioners do not provide telephone consultations. It is a priority of the staff and providers at FWMG to answer emergent phone calls in a timely manner. Our staff may be able to answer simple, routine questions for you, but in general non-emergency concerns should be addressed at a scheduled office visit. Non-emergent phone calls are not covered by your insurance company. Emergent calls will be directed to the on-call physician after triage by our staff or the telephone exchange service. If you have a life threatening emergency, call 911.

Privacy. We make every effort to protect your privacy and maintain your medical information in a confidential manner. FWMG has a Health Information Portability and Accountability Act (HIPAA) office policy in place which describes how your protected health information may be used and disclosed and how you can obtain access to this information. Please ask our staff for a copy of our Notice of Privacy Practices. With a few exceptions defined by federal law, we cannot release any of your medical information to anyone, including your spouse and/or other family members, without your specific written consent. Your request for release of information must be made in person; we do not accept phone, fax or mailed requests.

Chaperones. A staff member is always available to be in attendance as a chaperone during any part of your office visit. If you wish to have a chaperone present during all or part of your visit, simply indicate this to your provider or to her medical assistant. Under some circumstances a medical assistant or other chaperone may be present during your office visit at your provider's request.

Test Results. We will notify you of your laboratory and radiology results by mail. We ask that you please not call our office for these results unless you have not received the information in a timely manner. It is important to note that our office does not receive many test results for several days or even weeks.

Payment. Payment is expected at the time of service. We accept payment in the form of cash, check or credit card. We will bill your insurance as a courtesy to you; however, you are responsible for providing us with the appropriate billing information. It is also your responsibility to determine covered services through your individual health plan. We are required by insurance contracts to collect any co-pay or deductible due on the date of service. Any service not covered by your health insurance must be paid for on the date of service. Your full co-pay amount is due at the time of service.

Medicare. FWMG is a participating provider for Medicare. It is your responsibility to provide us with your Medicare card and endorse the assignment of benefits from the bill to the office.

Out-of-Pocket Expenses. The following services are not covered by insurance:

- Missed appointment (cancelled in less than 24 hours) $50
- Returned check $35
- Medical records request (no charge to requesting physician) $35 per request
- Disability and other forms $35

Prescription Refills. It is your responsibility to obtain written prescriptions with a year's refills at the time of your annual exam. This will eliminate the need to contact us for refills between visits. It is your pharmacist's responsibility, not FWMG's, to authorize refills which we have already written, or to transfer a prescription to another pharmacy at your request. With rare exceptions, for your safety, we do not call in or FAX prescriptions, including refills, after business hours. If you need a medication refill or change in medications prior to your next scheduled visit, you will need to call our office for an appointment.

Eligible Facilities. Many insurance carriers require that you use specific providers, including laboratory and radiology services. It is your responsibility to determine which providers are contracted with your insurance carrier. FWMG utilizes outside laboratory and radiology services. You will receive a separate bill if appropriate from these facilities.

Cancellations. If you are unable to keep your appointment, we ask that you kindly call our office at least 24 hours prior to your appointment in order to reschedule. If you fail to keep an appointment without canceling at least 24 hours in advance, you will be charged $50 for that missed appointment. This charge will not be covered by your insurance. Once payment is received in full for the missed appointment, we will schedule another appointment. If you continue to miss appointments, you will be dismissed from this practice.

Respect. We do our best to offer you excellence in medical care in an atmosphere of comfort and respect. In turn, we ask that you respect our staff and other patients by cooperating with our policies. If you have questions and/or concerns about FWMG's policies, please ask to speak with our administrator. We value your input and appreciate your suggestions.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

Physician Assistants are licensed and regulated by the Physician Assistant Committee, (916) 561-8780, www.pac.ca.gov

Thank you for your trust and allowing us the privilege of caring for you.

I have read and agree to these policies, and have received a copy of FWMG's Office Policy document.

Print Name_____ Date of birth_____

Patient Signature_____ Date_____

FWMG Staff_____ Date_____

E-PRESCRIBING PBM CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions**— This gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions---** Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Fresno Women's Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed)_____ **Date of Birth**_____
Patient Signature/Representative_____
Date _____ **Relationship to Patient** _____

Consent Denied _____ **Date** _____

Our providers are committed to your health and cancer prevention. To best serve you, we need a detailed personal and family cancer history. Please fill out the back of this form. If you have questions please ask the medical assistant or your provider.

If you filled this out within the **last 6 months** and nothing has changed you do not need to fill it out again. Just SIGN it and indicate "NO CHANGES" on the form.

THANK YOU!

(TURN OVER)

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth: _____ Age: _____ **Height:** _____ **Weight:** _____
Age of First Period: _____ **Age of First Child (if applicable):** _____ **Are you Menopausal:** Yes or No
Have you ever used Hormone Replacement Therapy? Yes or No **If Yes, how long?** _____
Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Please indicate if there is a **personal or family history** of any of the following cancers. If yes, then **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.
Example: Colon Cancer *Brother 36 yrs* *Aunt 44 yrs* *Grandfather 65 yrs* *Cousin 58 yrs*

BREAST AND OVARIAN CANCER (HBOC)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	**Breast cancer**				
Y	N	**Breast cancer in both breasts OR multiple primary breast cancers**				
Y	N	**Ovarian cancer**				
Y	N	**Male breast cancer**				
Y	N	**Are you of Ashkenazi Jewish descent?**				

COLON AND UTERINE CANCER (LYNCH)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	**Uterine (endometrial) cancer**				
Y	N	**Colon cancer**				
Y	N	**Ovarian, stomach, kidney, brain OR small bowel cancer**				
Y	N	**10 or more colon polyps in a lifetime**				

Y	N	**Prostate Cancer (HBOC)**				
Y	N	**Melanoma (HBOC)**				
Y	N	**Pancreatic Cancer (HBOC/Lyn)**				
Y	N	**Other Cancers**				

Patient's Signature: _____ Date: _____

FOR OFFICE USE ONLY
Patient offered hereditary cancer testing?
☐ YES ACCEPTED DECLINED **HEALTH CARE PROVIDER SIGNATURE:** _____
☐ NO Patient's Signature: _____

HBOC - Personal or Family History (Derived from NCCN)

One person with: (out to 2nd degree)
-Breast CA (diagnosed ≤45)
-Ovarian CA, any age
-Male breast CA, any age
-Bilateral breast CA (1st cancer dx'd ≤50)
-Triple negative Breast CA (dx'd ≤60)

Two persons with: (out to 2rd degree)
-Breast Cancer (at least 1 dx'd ≤ 50)

Three Persons with: (out to 2rd degree)
Combination breast/pancreatic/aggressive prostate cancer at any age

NOTE:
A. Lower threshold for testing in Ashkenazi Jewish individuals.
B. 3rd degree blood relative with breast cancer and/or ovarian cancer with 2 or more close blood relatives with breast cancer (at least 1 breast cancer dx'd at or under age 50) and/or ovarian cancer.
C. Limited family structure (fewer than 2 female 1st or 2nd degree relatives living past age 45) may mask a mutation in a family any age

Lynch*- Personal or Family History (Derived from SGO)

One person with: (out to 2nd degree)
-Endometrial or Colorectal Cancer (1 diagnosed ≤50)
-CRC, endo, or ovarian cancer along with another Lynch associated cancer in the same individual (2 primaries, any age)

2 persons:
1 person with ater onset (>50) endo or CRC and 1 person with an early onset (<50) other Lynch-related cancer

Three persons with: (out to 2nd degree)
-Lynch* cancers with 1 being Endometrial or Colorectal, any age

*Endo, CRC, ovarian, stomach, brain, pancreas, small bowel, ureter/ renal pelvis, biliary tract, sebaceous adenomas

Updated 09/2013

Fresno Women's Medical Group

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
ADDRESS:			
CITY:	STATE/ZIP:		
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )		
EMPLOYER:	INSURANCE:		
NAME YOU WOULD LIKE US TO USE:			
NAME OF SPOUSE/PARTNER:	EMERGENCY CONTACT:		
	RELATIONSHIP:		
	HOME TELEPHONE: ( )	WORK TELEPHONE: ( )	
REFERRED BY:			
WHY HAVE YOU COME TO THE OFFICE TODAY?			
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A ☐ PRIMARY CARE VISIT OR ☐ GYNECOLOGY ONLY			
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT'S LASTED.			

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO REGULAR BREAST SELF-EXAMINATIONS?	

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS?
1.						
2.						
3.						
4.						

PHYSICIAN'S NOTES ON OBSTETRIC HISTORY:

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED—CAUSE: AGE: FATHER: ☐ LIVING ☐ DECEASED—CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
DRINKING OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	☐	☐	
RECREATIONAL DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	

PERSONAL PROFILE

SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL
MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE U.S.? LOCATION:

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
SEXUALLY TRANSMITTED DISEASE				
HIV/AIDS				
HEART ATTACK/PROBLEMS				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
COLLAGEN VASCULAR DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/HIATAL HERNIA/ULCERS				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

PERSONAL PAST HISTORY OF ILLNESSES *(Continued)*

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS–DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA VACCINE		PNEUMOCOCCAL VACCINE	
MEASLES–MUMPS–RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	

PHYSICIAN'S NOTES:

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
1. CONSTITUTIONAL				
WEIGHT LOSS	☐	☐	☐	
WEIGHT GAIN	☐	☐	☐	
FEVER	☐	☐	☐	
FATIGUE	☐	☐	☐	
CHANGE IN HEIGHT	☐	☐	☐	

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
2. EYES				
DOUBLE VISION	☐	☐	☐	
SPOTS BEFORE EYES	☐	☐	☐	
VISION CHANGES	☐	☐	☐	
GLASSES/CONTACTS	☐	☐	☐	
3. EAR, NOSE, AND THROAT				
EARACHES	☐	☐	☐	
RINGING IN EARS	☐	☐	☐	
HEARING PROBLEMS	☐	☐	☐	
SINUS PROBLEMS	☐	☐	☐	
SORE THROAT	☐	☐	☐	
MOUTH SORES	☐	☐	☐	
DENTAL PROBLEMS	☐	☐	☐	
4. CARDIOVASCULAR				
PAINFUL BREATHING	☐	☐	☐	
CHEST PAIN OR PRESSURE	☐	☐	☐	
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐	
SWELLING OF LEGS	☐	☐	☐	
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐	
5. RESPIRATORY				
WHEEZING	☐	☐	☐	
SPITTING UP BLOOD	☐	☐	☐	
SHORTNESS OF BREATH	☐	☐	☐	
CHRONIC COUGH	☐	☐	☐	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	☐	☐	☐	
BLOODY STOOL	☐	☐	☐	
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐	
CONSTIPATION	☐	☐	☐	
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐	
7. GENITOURINARY				
BLOOD IN URINE	☐	☐	☐	
PAIN WITH URINATION	☐	☐	☐	
STRONG URGENCY TO URINATE	☐	☐	☐	
FREQUENT URINATION	☐	☐	☐	
INCOMPLETE EMPTYING	☐	☐	☐	
INVOLUNTARY/UNINTENDED URINE LOSS	☐	☐	☐	
URINE LOSS WHEN COUGHING OR LIFTING	☐	☐	☐	
ABNORMAL BLEEDING	☐	☐	☐	
PAINFUL PERIODS	☐	☐	☐	
PREMENSTRUAL SYNDROME (PMS)	☐	☐	☐	
PAINFUL INTERCOURSE	☐	☐	☐	
FIBROIDS	☐	☐	☐	
INFERTILITY	☐	☐	☐	
DES EXPOSURE	☐	☐	☐	
ABNORMAL VAGINAL DISCHARGE	☐	☐	☐	
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS	☐	☐	☐	

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
8. MUSCULOSKELETAL *(Continued)*				
MUSCLE OR JOINT PAIN	☐	☐	☐	
9a. SKIN				
RASH	☐	☐	☐	
SORES	☐	☐	☐	
DRY SKIN	☐	☐	☐	
MOLES	☐	☐	☐	
9b. BREASTS				
PAIN IN BREAST	☐	☐	☐	
NIPPLE DISCHARGE	☐	☐	☐	
LUMPS	☐	☐	☐	
10. NEUROLOGIC				
DIZZINESS	☐	☐	☐	
SEIZURES	☐	☐	☐	
NUMBNESS	☐	☐	☐	
TROUBLE WALKING	☐	☐	☐	
SEVERE MEMORY PROBLEMS	☐	☐	☐	
FREQUENT OR SEVERE HEADACHES	☐	☐	☐	
11. PSYCHIATRIC				
DEPRESSION OR FREQUENT CRYING	☐	☐	☐	
SEVERE ANXIETY	☐	☐	☐	
12. ENDOCRINE				
HAIR LOSS	☐	☐	☐	
HEAT/COLD INTOLERANCE	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	
HOT FLASHES	☐	☐	☐	
13. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	☐	☐	☐	
CUTS DO NOT STOP BLEEDING	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	
14. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES	☐	☐	☐	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
OTHER ALLERGIES	☐	☐	☐	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE NURSE ☐ PHYSICIAN ☐ OTHER:

SIGNATURE OF PATIENT:

DATE REVIEWED BY PHYSICIAN WITH PATIENT: / / PHYSICIAN SIGNATURE:

ANNUAL REVIEW OF HISTORY

DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DATE REVIEWED: / /	PHYSICIAN SIGNATURE: