- HIPAA (Health Insurance Portability and Accountability Act of 1996) allows for Infections Managed, Inc. and certain associated entities to use your protected health information for treatment, payment, or healthcare operations.
- Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information.
- The terms of our Notice of Privacy Practices may change over time, as allowed by law, if so, you will be notified at your next visit to update your signature/date.
- By signing this form, you:
    - Attest that you have had the opportunity to review our Notice of Privacy Practices, were able to ask questions and get clarifications on anything you didn't understand.
    - Agree to disclosure of your protected healthcare information as defined in the Notice of Privacy Practices.
- You have the right to revoke this consent in writing at any time and all disclosures will then cease. However, such a revocation will not be retroactive.
- The practice may condition receipt of treatment upon execution of this consent.

I am ☐ the patient, ☐ patient's parent ☐ patient's legal guardian of Infections Managed, Inc. I hereby acknowledge I was given the option of receiving a copy or reviewing Infections Managed, Inc's. Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Medicare Beneficiary Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Infections Managed, Inc. and/or Stephen A. Renae, M.D., for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?..... ..... ☐ Y ☐ N Has treatment been authorized by the V.A.?.....☐ Y ☐ N

Do you or your spouse have other insurance?.....☐ Y ☐ N Are you covered under the Black Lung Program?.....☐ Y ☐ N

Are you disabled or have end stage renal disease?☐ Y ☐ N Is there Medigap coverage secondary to Medicare?.....☐ Y ☐ N

Is illness/injury the result of an auto accident?..... ☐ Y ☐ N Is there insurance coverage primary to Medicare?..... ...☐ Y ☐ N

Did illness/injury occur at work?.....☐ Y ☐ N Is there employer supplemental coverage secondary…☐ Y ☐ N to Medicare?

Medigap (Medicare Secondary Insurance) Beneficiary Authorization

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Infections Managed, Inc. and/or Stephen A. Renae, M.D., for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to my Medigap Coverage Plan any information needed to determine these benefits payable for related services. I understand that I am responsible for payment of any balance not paid by my Insurance Company.

Commercial/Managed Care Beneficiary Authorization

Assignment of Insurance Benefits

I hereby authorize payment directly to Infections Managed, Inc. for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this agreement, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy.

General

Release of Information

I hereby authorize Infections Managed, Inc. to disclose to my insurance company(s) copies of my medical records(s) to obtain payment for services or as part of a payment review of medical services, or in the case of Workers Compensation claims, to my present or past employer(s). Additionally, I authorize Infections Managed, Inc. to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose of such information. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.

Agent

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for purposes of patient identification.

Financial Agreement

In consideration of the services rendered to the below named patient, the undersigned agrees to pay Infections Managed, Inc. in accordance with its regular charges and terms and, if this account is referred to an attorney or agency for collection, to pay attorney(s) fees, court costs, and collection expenses. I also agree to be responsible for charges not covered by insurance. I understand that my obligation to pay Infections Managed, Inc. may not be deferred for any reason, including pending legal action against other parties, to recover medical costs

Copy

I permit a copy of this authorization to be used in place of my original signature.

The undersigned certifies that each has read and understands the above terms and conditions.

Patient Name (Please Print)	Patient Signature	Date Signe
Patient's Agent Representative and Guarantor Name (Please Print)	Patient's Agent Representative and Guarantor Signature	Date Signed

Authorization to Release Protected Health Information

Patient Information:

Full Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Date of Birth

I Hereby Authorize:

☐ Infections Managed, Inc. 4800 NE 20 Terrace, #115, Ft. Lauderdale, FL 33308 PH (954) 776-9992 FAX (954) 776-9993
☐ Other:

Name/Org _____

Address _____

City _____ State _____ Zip Code _____

Phone Fax E mail

To Release My Protected Health Information To:

☐ Infections Managed, Inc. 4800 NE 20 Terrace, #115, Ft. Lauderdale, FL 33308 PH (954) 776-9992 FAX (954) 776-9993
☐ Other:

Name/Org _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____ E mail _____
☐ Other:

Name/Org _____

Address _____

City _____ State _____ Zip Code _____

Phone Fax E mail

Purpose of PHI Released

☐ Treatment/Continued Care ☐ Personal ☐ Application for Insurance
☐ Legal Purposes ☐ Payment of Insurance Claim ☐ Disability Determination

☐ Other:

Information To Be Released

(Required - check all that apply)

☐ Clinic Notes	☐ History and Physical	☐ Consult Notes	☐ Discharge Summary
☐ Laboratory Reports	☐ Microbiology Reports	☐ Operative Reports	☐ Radiology Reports
☐ Hospital Notes	☐ Immunization Records	☐ Pathology Reports	☐ Billing Information

☐ Other (specify information to be released in the space below):

Dates of Service (MMDDYYYY)

From		To		Information Needed By:	

Valid Dates (MMDDYYYY)

This authorization will automatically expire one year from the date of signing unless I indicate otherwise below.

Valid From:		Valid To:	

Authorization

_____By **initialing** this area, I authorize the release of my health records that may include information indicating the presence of communicable or venereal diseases, which may include, but are not limited to: hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS or Human Immune Deficiency Virus (HIV).
_____By **initialing** this area, I authorize the release of my health records that may include information about genetic disorders or genetic testing.
_____By **initialing** this area, I authorize the release of my health records that may include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.
This request is made voluntarily and the information given herein is accurate to the best of my knowledge.
I may revoke this authorization at any time in writing to the provider/facility releasing the information, but if I do, it will have no effect on actions taken prior to receiving the revocation.
I understand that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by federal law.
Dr. Renae/Infections Managed, Inc. will not condition treatment on whether or not I sign the authorization.
I may be charged for copies in accordance with state law.

Signature

My signature is required to validate this Authorization. If I sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.
• If the patient is 18 years of age or older, the patient must sign and date the form.
• If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.
• If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

Print Name _____

Signature _____

Date Signed _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Conservator ☐ Health Care Power of Attorney

Thank you for choosing us as your Infectious Diseases provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Payment Types Our office accepts the following forms of payment: Cash, Cashier's check, Bank check and credit cards. Credit cards accepted include Visa and MasterCard. The office does not accept American Express, Discover or Diners Club cards.

8. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your

account to a collection agency and may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Name (Please print)	
Signature	
Date Signed	
Relation to patient	☐ Self ☐ Parent ☐ Guardian ☐ Spouse ☐ Friend ☐ Other

FILLING OUT THIS FORM ACCURATELY HELPS US SERVE YOU BEST. ASK ONE OF OUR STAFF MEMBERS FOR HELP IF YOU DON'T UDERSTAND SOMETHING ON THIS FORM. PLEASE PRINT CLEARLY.

DEMOGRAPHICS

Last Name:		First Name:		M.I.	
Today's Date:		Appointment Date:			
Date of Birth		Referred By:			
Home Address:					
Home Address					
City		State		Zip Code	
Home Phone		Cell Phone		Work Phone	
Fax Number		E mail Address			
Sex	☐ M ☐ F	Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		
SS# (Last 4)					

PREFERRED CONTACT METHOD(S) How would you like our office to correspond with you? Check all that apply.

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ E mail ☐ Texts ☐ Mail ☐ None

I grant Infections Managed permission to send me e-mails/texts with appointment reminders, exclusive content and any other healthcare information that could be useful. I am aware I can unsubscribe from the list at any time. I agree to notify the office that I don't want to receive e-mails any longer before reporting spam.

EMERGENCY CONTACT INFORMATION

Name		Relation	
Contact Number			

OTHER CONTACTS Please list any contacts you want us to communicate with or share your medical information.

Name		Phone #	
Name		Phone #	
Name		Phone #	

PRIMARY PHYSICIAN (The physician that provides most of your healthcare)

Name		Phone #	
Did he/she refer you to us?			

OTHER PHYSICIANS Please list any physicians you want us to communicate with or share your medical records.

Name		Phone #	
Name		Phone #	
Name		Phone #	

PHARMACY INFORMATION

Name		Phone #		Mail-order?	☐ Y ☐ N

EMPLOYER INFORMATION ☐ Unemployed

Employer Name		Job Title			
Address					
City		State		ZipCode	
Supervisor					

RACE/ETHNICITY					
Do you consider yourself Hispanic?	☐ Yes ☐ No	Preferred Language Spoken:	☐ English ☐ Other_____		
Race:	☐ White	☐ Black		☐ Native American and Alaska Native	
	☐ Asian	☐ Native Hawaiian and Other Pacific Islander		☐ Some other race	
HOW DID YOU HEAR ABOUT US?					
☐ Physician	☐ Family	☐ Friend	☐ Internet/Social Media	☐ Hospital	
☐ Healthcare Professional	☐ Insurance Co. Directory	☐ Yellow Pages	☐ Other		

HEALTH INSURANCE INFORMATION								
Policyholder Name	☐ Self							
Policyholder SS# (last 4)			Policyholder D.O.B.					
Relationship to Pt.			Policyholder Employer					
Policy Type:	☐ PPO	☐ HMO	☐ EPO	☐ BCBS	☐ MEDICARE	☐ MEDICAID	☐ OTHER	
Primary Insurance Co:			Secondary Insurance Co.					
Phone #			Phone#					
Member ID#:			Member ID#:					
Group/Policy#:			Group/Policy#:					
Effective Date			Effective Date					
Claims Address			Claims Address					
Claims Address			Claims Address					

DOCUMENTS
Please attach copies of your current driver's license (or other form of picture ID) and Health Insurance Card. Front and back.

SIGNATURE	
Name (Please print)	
Signature	
Date Signed	
Relation to patient	☐ Self ☐ Parent ☐ Guardian ☐ Spouse ☐ Friend ☐ Other

DEMOGRAPHICS

NAME: _____

DATE _____ DOB: _____

REASON FOR VISIT (CHIEF COMPLAINT)

_____

_____

_____

PAST MEDICAL HISTORY ☐ N/A

Please indicate below your history of diseases with an "X" in the appropriate box. Check off "C" if it is a current disease and "P" if it is a past disease. If you have never encountered a problem with a particular disease, please leave blank.

		C	P			C	P			C	P
K21.9	Acid Reflux (GERD)			T78.40	Allergies/Hay Fever			D64.9	Anemia		
F41.9	Anxiety			J45.909	Asthma			I48.91	Atrial fibrillation		
F31.9	Bipolar Disorder			J40	Bronchitis			T30.0	Burns		
C80.1	Cancer (site)							I42.9	Cardiomyopathy		
H26	Cataracts			E78.0	Cholesterol elevation			A40.7	C difficile enterocolitis		
I50.9	Congestive heart failure			J44.9	COPD			I25.10	Coronary atherscleroses		
K50.10	Crohn's Disease			I82.409	Deep vein thrombosis			F03.90	Dementia		
F32.9	Depression			E11.9	Diabetes			K57.92	Diverticulosis/it is		
F18.1	Drug Abuse			H66.90	Ear Infections(recurrent)			J43.9	Emphysema		
L30.9	Eczema			I38	Endocarditis (heart infection)			G40.909	Epilepsy (seizure)		
F52.21	Erectile Dysfunction			M79.7	Fibromyalgia			A60.9	Genital Herpes		
H40.9	Glaucoma			A54.9	Gonorrhea			M10.9	Gout		
R51	Headache			H91.90	Hearing loss			I21.3	Heart Attack		
R01.1	Heart Murmur			R12	Heartburn			K64.9	Hemorrhoids		
B18.9	Hepatitis, viral			B15.9	Hepatitis A			B19.10	Hepatitis B		
B18.2	Hepatitis C			M51.9	Herniated Disc(s)			B00.9	Herpes Simplex		
B02.9	Zoster (shingles)			B20	HIV/AIDS			I10	Hypertension		
E05.90	Hyperthyroidism			E03.9	Hypothyroidism			K58.9	Irritable bowel syndrome		
N20.0	Kidney stones			N18.9	Kidney disease, chronic			C95.90	Leukemia		
C85.90	Lymphoma			M32.9	Lupus (SLE)			G03.9	Meningitis		
G43.909	Migraine			G35	Multiple Sclerosis			E66.9	Obesity		
M19.90	Osteoarthritis			M86.9	Osteomyelitis (site)			M81.0	Osteoporosis		
G20	Parkinson's disease			K27.9	Peptic ulcers			I73.9	Peripheral vascular disease		
J18.9	Pneumonia			N40.0	Prostate enlargement			N41.9	Prostatitis		
L40.9	Psoriasis			N28.9	Renal disease			N19	Renal failure		
I00	Rheumatic fever			M06.9	Rheumatoid arthritis			M54.30	Sciatica		
J01.90	Sinusitis, acute			J32.9	Sinusitis, chronic			K51.90	Ulcerative colitis		

HOSPTIALIZATIONS/SURGERIES ☐ N/A

Types (M=Medical, S=Surgical or P= Psychiatric)

DATE(S)	REASON	DURATION	TYPE

MAJOR INJURIES OR ACCIDENTS ☐ N/A

Please list

MEDICATIONS ☐ N/A

List all prescription and non-prescription medications, vitamins, home remedies, birth control pills and herbal preparations you're taking currently.

MEDICATION	DOSE

MEDICATION ALLERGIES ☐ N/A

MEDICATION	LOCATION AND REACTION (SKIN, LOCAL, ABDOMINAL, ANAPHYLACTIC)	VERY MILD, MILD, MODERATE, SEVERE

NON MEDICATION ALLERGIES ☐ N/A

ALLERGEN (EX: FOOD, TAPE, LATEX)	LOCATION AND REACTION (SKIN, LOCAL ABDOMINAL, ANAPHYLACTIC)	VERY MILD, MILD, MODERATE, SEVERE

FAMILY HISTORY

Have any of your blood relatives had any of the following diseases? Please document which family member(s) in the space provided.

YES	NO	DISEASE	RELATIVE(S) EX: MOTHER, FATHER, AUNT, UNCLE, COUSIN
		Cancer	
		Diabetes mellitus	
		Heart disease	
		High blood pressure	
		High cholesterol	
		Kidney disease	
		Osteoporosis	
		Stroke	
		Thyroid disease	
		Tuberculosis	
		Other:	
		Other:	
		Other	

SOCIAL HISTORY

In what type of dwelling do you reside? ☐ House ☐ Apartment ☐ Townhome ☐ Villa ☐ Mobile Home

☐ Other specify:

Does anyone live at home with you? If so, who?

Do you have any hobbies? If so, briefly describe.

Do you have any pets? If so, please list them

Different culinary habits? Ex: raw fish, raw steak, etc.

Is spirituality important to you? ☐ No ☐ Yes

Would you like to discuss spiritual matters with your physician? ☐ No ☐ Yes

IMMUNIZATIONS / TRAVEL HISTORY ☐ N/A

Have you ever had any of the following immunizations; if so when?

Hepatitis A		Hepatitis B	
Influenza (Flu Shot)		Measles	
Rubella		Tetanus	
Pneumonia (Pneumovax/Prevnar)		Other	

IMMUNIZATIONS / TRAVEL HISTORY (CONTD.)

Have you ever had any of the following immunizations; if so when?

Varicella (Chicken pox) or illness			
BCG (Tuberculosis vaccine)		PPD (Tuberculosis test)	

Have you ever-been diagnosed with tuberculosis? If yes, when were you treated?

How long were you treated for?

Previous cities and states visited within the United States:

Have you traveled outside of the United States? If so, where and when did you travel?

RISK ASSESSMENT

Tobacco Use:

□ Never used. □ Quit; when _____ How long used? _____

Current use: □ Cigarettes_____ packs per day. □ Pipe □ Chewing tobacco

How long have you been using?_____months/years.

Are you interested in information about quitting? □Yes □No.

Alcohol use:

Do you drink alcohol (beer, wine or spirits)? □ No □ Yes; Number of drinks per week:_____

Is your alcohol use a concern to you or others? □ Yes □ No

Are you interested in trying to quit? □ Yes □ No.

Drug Use:

Do you use recreational drugs? □ No □ Yes; How long have you been using?_____

Which substances have you been using? Please check below:

□ Marijuana □Cocaine □Crack cocaine □Heroin □ Methamphetamines □Opioids □Others_____

Do you share needles? □ Yes □ No □N/A.

Are you interested in trying to quit? □ Yes □ No.

Piercings/Tattoos:

Do you have piercings or tattoos? If so, where and when did you get them done?_____

Diet:

How do you rate your diet? □ Good □ Fair □ Poor. Height: _____ Weight_____lbs.

Are you satisfied with your weight? □ Yes □ No. If no, what are you doing about it?

Advance Directives:

Do you have a living will? □ Yes □ No.

RISK ASSESSMENT (CONTD)
Are you interested in information regarding living wills? ☐ Yes ☐ No.

Caffeine Intake:

☐ No ☐ Yes ☐ Coffee/Tea:_____ cups/day ☐ Soda: _____cans, glasses /day
☐ Chocolate: _____ oz. /day

Sexual Activity:

Are you sexually active: ☐ No ☐ Yes ☐ Not currently
Current sex partner(s) is/are: ☐ Male ☐ Female ☐ Both
Do you have multiple partners? ☐ No ☐ Yes. Are you interested in changing this behavior? ☐ Yes ☐ No
Do you practice safer sex? ☐ No ☐ Yes. If yes, what methods do you use?
Have you have ever had sexually transmitted diseases? If so when?
☐ Gonorrhea ☐ Syphilis ☐ Chlamydia ☐ HPV ☐ Hepatitis ☐ Trichomonas ☐ Others:
Have you ever been tested for HIV? ☐ No ☐ Yes If so when was your last test?
Was it negative or positive? ☐ Negative ☐ Positive

REVIEW OF SYSTEMS

Review of Systems (Place a check mark next to the symptoms you are experiencing currently)

General	Dry mouth	Yellow eyes or skin
☐ Weight loss or gain	☐ Sore throat	**Urinary**
☐ Fatigue	☐ Hoarseness	☐ Frequency
☐ Fever or chills	☐ Thrush	☐ Urgency
☐ Weakness	☐ Non-healing sores	☐ Burning or pain
☐ Trouble sleeping	**Neck**	☐ Blood in urine
Skin	☐ Lumps	☐ Incontinence
☐ Rashes	☐ Swollen glands	☐ Change in urinary strength
☐ Skin Lumps	☐ Neck Pain	**Vascular**
☐ Skin Itching	☐ Neck Stiffness	☐ Leg cramping
☐ Skin Dryness	**Breasts**	☐ Calf pain with walking
☐ Skin Color changes	☐ Lumps	**Musculoskeletal**
☐ Hair and nail changes	☐ Pain	☐ Muscle or joint pain
Head	☐ Discharge	☐ Stiffness
☐ Headache	☐ Self-exams	☐ Back pain
☐ Head injury	☐ Breast-feeding	☐ Redness of joints
☐ Neck Pain	**Respiratory**	☐ Swelling of joints
Ears	☐ Cough	☐ Trauma
☐ Decreased hearing	☐ Sputum	**Neurologic**
☐ Ringing in ears	☐ Coughing up blood	☐ Dizziness
☐ Earache	☐ Shortness of breath	☐ Fainting
☐ Drainage	☐ Wheezing	☐ Seizures

REVIEW OF SYSTEMS (CONTD.)		
Eyes	☐ Painful breathing	☐ Weakness
☐ Vision Loss/Changes	**Cardiovascular**	☐ Numbness
☐ Glasses or contacts	☐ Chest pain or discomfort	☐ Tingling
☐ Pain	☐ Tightness	☐ Tremor
☐ Redness	☐ Palpitations	**Hematologic**
☐ Blurry or double vision	☐ Shortness of breath with activity	☐ Ease of bleeding
☐ Flashing lights	☐ Difficulty breathing lying down	☐ Ease of bruising
☐ Specks	☐ Swelling	**Endocrine**
Nose	☐ Sudden awakening from sleep with	☐ Change in appetite
☐ Stuffiness	☐ Shortness of breath	☐ Head or cold intolerance
☐ Discharge	**Gastrointestinal**	☐ Sweating
☐ Itching	☐ Swallowing difficulties	☐ Frequent urination
☐ Hay fever	☐ Heartburn	☐ Thirst
☐ Nosebleeds	☐ Change in appetite	**Psychiatric**
☐ Sinus pain	☐ Nausea	☐ Nervousness
Throat	☐ Change in bowel habits	☐ Stress
☐ Bleeding	☐ Rectal bleeding	☐ Depression
☐ Dentures	☐ Constipation	☐ Memory loss
☐ Sore tongue	☐ Diarrhea	

SIGNATURE							
By signing below I certify the information above is accurate truthful and correct to the best of my knowledge.							
Signee:	☐	Patient	☐	Power of Attorney	☐	Family member	☐ Other
Signature					Date		