**This form should be filled out completely**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*First Name Middle Initial Last Name*

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address City State Zip Code*

Does the patient currently live at one of the following types of facilities? Nursing or Rehab Assisted living

Are you in hospice? Yes No

Gender: *(Circle One)* Male Female  **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Phone #’s Home (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a voicemail message? Yes No

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: single married widowed divorced

Have you been known by another name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race:** *(please circle one)*

Arab Asian African America Caucasian Native American Pacific Islander I decline to answer this question

**Ethnicity:**  Hispanic/Latino Non-Hispanic I decline to answer this question

**Preferred Language : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician** (Family Doctor, Pediatrician, Internal Medicine Doctor)

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

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City location of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about our office** (circle one) Dr. Referral Family/Friend Patient Other

**Pharmacy** (indicate local or mail order)

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (local or mail order - circle one)

Pharmacy Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address or Cross Street / City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Pharmacy Name (if using both local and mail order) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I authorize my physician and or administrative staff to disclose my PHI to the following persons (initial next to all desired selections)

\_\_\_\_\_\_ Myself only

\_\_\_\_\_\_ My spouse or significant other (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_\_\_\_ My parents (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_\_\_\_ My children(specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_\_\_\_ Other persons (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**My preferred method of contact is:**

Land line/home phone) (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the box below regarding the office staff or physician leaving information or confirming appointments on my answering machine, voice mail or with my answering service.

* No, I do not want any information left on any message systems
* Yes, I give permission for only non-medical messages and appointment reminders to be left on my message system
* Yes, I give my permission for medical information, non-medical messages and appointment reminders to be left on my message system

This authorization shall be in force and effective until revoked, at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy officer at the address below. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or state law.

**X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

*Signature of Patient (or patient parent/guardian if the patient is under 18) Date of signature*

**Financial Policy**

We appreciate your confidence in choosing Franklin Neurology. *Please*, take a moment to review our **financial policy** below:

*About Co Payments:*

*If you are an enrollee of a Health plan (HMO, PPO, POS, MC etc.), you are required to pay your co-payment: your responsibility for any Office Visit, each time an office visit is billed. This must be paid on the date of service. If you are not prepared to pay on the date of service, you must reschedule.*

*About Annual Deductibles:*

*In addition to co-pays for office visits, most health care plans have annual deductibles. If you have not met that deductible, you will be billed for your portion after your insurance company rejects the claim. You should receive an “Explanation of Benefits” that will tell you what your financial responsibility is for any visits or procedures done in this office. If you have Master Medical, you are responsible for payment since you will receive a check from your insurance company, payable to you.*

*In the event there is a balance due from YOU after your insurance company has paid its portion, we will bill you. We would appreciate prompt payment of your bill after the first statement. The name of the practice (and the name appearing on the bill is:* **Michigan Health Professionals, P.C.***)*

*If you are unclear as to the reason (remember to check your Explanation of Benefits, provided by your insurance company) do not hesitate to contact the office and leave a message for our biller. She will investigate your concerns and return your call promptly to answer any questions you might have. If you have questions regarding a laboratory bill, please direct your billing questions to the laboratory, not our office.*

*About Self-Pay (No insurance or NON-covered services such as cosmetic procedures):*

*If you do not have insurance, you must pay at the time of service or purchase. We cannot bill you. We accept cash, checks and Visa, Master Card, Discover and American Express.*

*About Failure to Pay for Medical Care:*

*If you fail to timely pay your medical bills or amounts owed to us for your medical care and a mutually agreeable suitable resolution cannot be reached (e.g., A mutually agreeable payment plan), we reserve the right after giving you 30 days prior written notice to stop providing medical care to you and to end the physician’s relationship with you as a patient.*

*About Referrals:*

*Many HMO’s now allow self-referrals to Specialists (such as Neurology) and you do not need a written referral to be seen as long as your plan is within the same network. Otherwise, if your insurance plan requires that your Primary Care Physician (Internal Medicine, General Practitioner, Pediatrician, etc.) issues a referral to be seen in our office, please check with the office staff to determine which physicians participate with your plan and either bring a referral with you or have your PCP fax over your referral prior to your visit. If you arrive for your office visit without a referral you have two options:*

1. *Reschedule*
2. *You may pay for the visit prior to the start of your visit.*

*Our staff is dedicated to working with you and your insurance carrier to get the best possible reimbursement. Patients also have, however, a certain responsibility to be aware of the scope of their coverage. In addition, to make sure that billing is done appropriately please update the office with ANY changes to your insurance (new card, new numbers, different co-pays), your address and phone information. We will verify this information at each visit by asking to see your insurance card and inquire about any changes in your demographics. We appreciate your patience in working with our staff.*

*Please sign below and return this prior to your visit.*

*I have read the above and understand my obligations.*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

*Signature of Patient (or parent/ guardian if the patient is a minor) Date signed*

I hearby authorize Richard M. Trosch, MD or Brian N. Kirschner MD to release to my insurance company/companies or it’s representatives any information including my diagnosis and medical records of any treatment or examination rendered.

***Finally, in the unlikely event that an employee of this practice is stuck by a needle or another sharp instrument during or following a procedure that involves your blood, you will be asked to submit to a blood test for diseases contracted through contact with body fluids (blood). This is MANDATED by OSHA and is meant to protect you and our staff. Any procedure that involves cutting or injecting into the skin requires that you sign this, otherwise, no procedure can be performed.***

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

*Signature of Patient (or parent/ guardian if the patient is a minor) Date signed*

**Your signature is an acknowledgement that you are aware of the posted “Notices of Privacy Practices” of Franklin Neurology and that a copy is available upon request.**

**X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_**

***Signature of Patient (or parent/ guardian if the patient is a minor) Date signed***

**Pertinent Medical History and Intake Form**

IMPORTANT: briefly state the reason for your visit:

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

**Past Medical History:** *(please circle any that apply)*

Aneurysm

Arthritis

Anxiety Disorder

Asthma

Back or neck pain

Bipolar

Bleeding disorder

Cancer

COPD/emphysema

Coronary artery disease/MI/angina

COVID-19

Depression

Diabetes

Fibromyalgia

Gait disorder

Gaucher’s liver disease

Head trauma/concussion/TBI

Headaches/migraine

Cardiac disease/valve disease

Cardiac arrhythmia

Hepatitis

Hypertension

Kidney disease/dialysis

High cholesterol

Liver disease

Lupus/autoimmune disease

Multiple Sclerosis

Osteoporosis

Schizophrenia

Seizures/epilepsy

Sleep disorder

Thyroid or endocrine

Ulcers or GI reflux

Tremor

None of the Above

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History:** *(please circle any that apply)*

Brain surgery Coronary angioplasty Shoulder surgery

CABG Gastric bypass Thoracic spine surgery

Carotid endarterectomy Hernia repair Thyroid surgery

Carpal tunnel release Hip surgery Tonsillectomy

Cataract surgery Hysterectomy Tubal ligation

Cervical spine surgery Knee surgery NPH VP shunt placement

Cholecystectomy Lumbar spine surgery DBS surgery

Other surgical procedures*(please list):*

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

**Neurological Disease History:** *(please list any past diagnosis)*

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

**Family History:** *(please list known illnesses in close relatives and their relationship to you)*

* Parkinson’s disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Tremor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Dystonia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Huntington’s disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Alzheimer’s or dementia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Gait disorder or ataxia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* RLS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cardiomyopathy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Kidney failure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Liver disease or Gaucher’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Stroke or heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other family history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:** *(list all medications, doses, and dosing frequency)*

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

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**Allergies:** *(please enter all medication allergies)*

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

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**Tell us more about you (***circle all that apply)*

Are you able to care for yourself Y Yes No

Are you able to walk without assistance? Yes No

Which of your hands is dominant Right Left

Do you live with a spouse Yes No

Are you currently employed Yes No

Have you ever smoked tobacco Yes No

What is your level of alcohol consumption None Occasional Moderate Heavy

Do you use recreational drugs Yes No

Do you have an advanced directive Yes No

Are you a caregiver Yes No

Where do you live Single level house Multilevel house Apartment Other Facility

What is your exercise level None Occasional Moderate Heavy

**Review of Systems: (***please circle any of the following symptoms you are experiencing)*

**Constitutional:** fever, night sweats, weight gain, weight loss **Eyes:** dry eyes, irritation, vision change

**Ears:** hearing loss, ear pain **Nose:** nosebleeds, sinus drainage, loss of sense of smell

**Throat:**,snoring, dry mouth, drooling **Cardiovascular:** shortness of breath, palpitations, lightheaded with standing

**Respiratory:** cough, wheezing, sleep apnea **Gastrointestinal:** abdominal pain, vomiting, loss of appetite, constipation

**Genitourinary:** urine incontinence, urinary frequency **Musculoskeletal:** joint pain, back pain, swelling of joints

**Skin:** rash, itching, seborrhea of scalp **Neurologic**: seizures, dizziness, severe headaches, restless legs

**Psychiatric:** depression, anxiety, hallucinations **Endocrine:** fatigue, increased thirst, cold intolerance

**Hematologic:** swollen glands, easy bruising