

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: [hhs.gov - Understanding Health Information Privacy](https://www.hhs.gov/understanding-health-information-privacy)

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial ____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initial ____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initial ____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initial ____

Females: Consent to X-Ray During Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initial ____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial ____

Financial Obligation

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initial ____

Insurance / Medicare payment-Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct.

I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to this clinic and/or doctor of record on my behalf for any services and materials furnished.

Initial ____

Signature

Date

Patient: _____

Health History Form

Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____

Over-The-Counter Medications

Over-the-counter medications taken on a regular or ongoing basis:

Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____



Vitamins, Minerals, Herbs, or Dietary Supplements

Vitamins, minerals, herbs, or dietary supplements taken on a regular or ongoing basis:

Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____



Diet and Exercise

Check if you have ever smoked cigars or cigarettes. Yes

Check if you still smoke. Yes

How much do you smoke? Less than one pack per week 1-2 packs per week

1 pack every two days 1 pack per day More than one pack per day

Check if you drink alcoholic beverages. Yes

How many alcoholic beverages do you consume per week? _____

Check if a physician has ever diagnosed you as an alcoholic. Yes

Check if a physician has ever diagnosed you with any liver-related problems. Yes

Check if you exercise regularly. Yes

How many days do you exercise each week? _____

Allergies

Check if a physician has ever diagnosed you with any allergies. Yes

Do you have Airborne allergies? Yes

- | | | | |
|-----------------------------------|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Animal | <input type="checkbox"/> Molds/Fungus | <input type="checkbox"/> Pollens | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cat Hair | <input type="checkbox"/> Cockroach | <input type="checkbox"/> Dog Hair | <input type="checkbox"/> Feather Mix |
| | <input type="checkbox"/> Guinea Pig Hair | <input type="checkbox"/> Dust Mites | <input type="checkbox"/> Other _____ |

Do you have Chemical allergies? Yes

- | | | | | |
|---|---|---|--|------------------------------------|
| <input type="checkbox"/> Acetone | <input type="checkbox"/> Acetylcholine | <input type="checkbox"/> Auto Exhaust | <input type="checkbox"/> Benzyl Alcohol | <input type="checkbox"/> Chlorine |
| <input type="checkbox"/> Citric Acid | <input type="checkbox"/> Cologne (all) | <input type="checkbox"/> Diesel Exhaust | <input type="checkbox"/> Dopamine | <input type="checkbox"/> Estradiol |
| <input type="checkbox"/> Ethanol | <input type="checkbox"/> Fluorine | <input type="checkbox"/> Formaldehyde | <input type="checkbox"/> Latex | <input type="checkbox"/> Melatonin |
| <input type="checkbox"/> Newspaper Print | <input type="checkbox"/> Norepinephrine | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Propylene | <input type="checkbox"/> Serotonin |
| <input type="checkbox"/> Silicone Implant | <input type="checkbox"/> Sponge Rubber | <input type="checkbox"/> Toluene | <input type="checkbox"/> Trichloroethylene | <input type="checkbox"/> Wood Pulp |
| | | <input type="checkbox"/> Xylene | <input type="checkbox"/> Other _____ | |

Do you have Drug allergies? Yes

- | | | | | |
|--|-------------------------------------|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Codeine | <input type="checkbox"/> Insulin Preparations | <input type="checkbox"/> Iodine | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Novocain | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ | |

Do you have Food allergies? Yes

- | | | | | |
|---|--|-------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Artificial Colorings | <input type="checkbox"/> Artificial Flavorings | <input type="checkbox"/> Beef | <input type="checkbox"/> Coffee/Tea | <input type="checkbox"/> Dairy |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish/Shellfish | <input type="checkbox"/> Fruits | <input type="checkbox"/> Lamb | <input type="checkbox"/> Nuts |
| <input type="checkbox"/> Pork | <input type="checkbox"/> Poultry | <input type="checkbox"/> Vegetables | <input type="checkbox"/> Other _____ | |



Surgical History

Check if you have any implants, screws, plates or other foreign objects in your body. Yes

- Bullet Wound(s) Infusion Catheter Ear Implant Pacemakers Eye Implant
 Brain Plate(s) Heart Valve(s) Shrapnel Other _____

Musculoskeletal Surgeries (Check if you have had any of the following surgeries)

- | | | | |
|---|---------------------------|-----------------------------------|---------------------------|
| <input type="checkbox"/> Ankle | Year(s) of surgery: _____ | <input type="checkbox"/> Head | Year(s) of surgery: _____ |
| <input type="checkbox"/> Back | Year(s) of surgery: _____ | <input type="checkbox"/> Hip | Year(s) of surgery: _____ |
| <input type="checkbox"/> Cosmetic or Augmentation | Year(s) of surgery: _____ | <input type="checkbox"/> Knee | Year(s) of surgery: _____ |
| <input type="checkbox"/> Elbow | Year(s) of surgery: _____ | <input type="checkbox"/> Neck | Year(s) of surgery: _____ |
| <input type="checkbox"/> Foot | Year(s) of surgery: _____ | <input type="checkbox"/> Shoulder | Year(s) of surgery: _____ |
| <input type="checkbox"/> Hand | Year(s) of surgery: _____ | <input type="checkbox"/> Wrist | Year(s) of surgery: _____ |
| <input type="checkbox"/> Other | Please describe: _____ | | Year(s) of surgery: _____ |

Organ System Surgeries (Check if you have had any of the following surgeries)

- | | | | |
|---|---------------------------|--|---------------------------|
| <input type="checkbox"/> Brain | Year(s) of surgery: _____ | <input type="checkbox"/> Intestine, large | Year(s) of surgery: _____ |
| <input type="checkbox"/> Colon | Year(s) of surgery: _____ | <input type="checkbox"/> Liver | Year(s) of surgery: _____ |
| <input type="checkbox"/> Esophagus | Year(s) of surgery: _____ | <input type="checkbox"/> Lung | Year(s) of surgery: _____ |
| <input type="checkbox"/> Eye | Year(s) of surgery: _____ | <input type="checkbox"/> Mastectomy | Year(s) of surgery: _____ |
| <input type="checkbox"/> Heart | Year(s) of surgery: _____ | <input type="checkbox"/> Reproductive Organs | Year(s) of surgery: _____ |
| <input type="checkbox"/> Kidney | Year(s) of surgery: _____ | <input type="checkbox"/> Skin | Year(s) of surgery: _____ |
| <input type="checkbox"/> Intestine, small | Year(s) of surgery: _____ | <input type="checkbox"/> Throat | Year(s) of surgery: _____ |
| <input type="checkbox"/> Other | Please describe: _____ | | Year(s) of surgery: _____ |
| <input type="checkbox"/> Transplant | Please describe: _____ | | Year(s) of surgery: _____ |

Your Cancer History

Check if a physician has ever diagnosed you with cancer. Yes

Check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Non-Hodgkin's Lymphoma |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Pancreatic |
| <input type="checkbox"/> Colon or Rectal | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Endometrial | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Basal Cell Carcinoma |
| <input type="checkbox"/> Kidney (renal cell) | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Stomach |
| | <input type="checkbox"/> Thyroid |
| | <input type="checkbox"/> Uterine |

Family Cancer History

Check if a physician has ever diagnosed your family with cancer. Yes

Check all that apply and the family member(s) who had this condition:

- | | |
|--|--|
| <input type="checkbox"/> Bladder (M, F, S, MG, PG) | <input type="checkbox"/> Lung (M, F, S, MG, PG) |
| <input type="checkbox"/> Brain (M, F, S, MG, PG) | <input type="checkbox"/> Non-Hodgkin's Lymphoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Breast (M, F, S, MG, PG) | <input type="checkbox"/> Ovarian (M, F, S, MG, PG) |
| <input type="checkbox"/> Cervical (M, F, S, MG, PG) | <input type="checkbox"/> Pancreatic (M, F, S, MG, PG) |
| <input type="checkbox"/> Colon or Rectal (M, F, S, MG, PG) | <input type="checkbox"/> Prostate (M, F, S, MG, PG) |
| <input type="checkbox"/> Endometrial (M, F, S, MG, PG) | <input type="checkbox"/> Skin (M, F, S, MG, PG) |
| <input type="checkbox"/> Eye (M, F, S, MG, PG) | <input type="checkbox"/> Basal Cell Carcinoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Kidney (renal cell) (M, F, S, MG, PG) | <input type="checkbox"/> Squamous Cell Carcinoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Leukemia (M, F, S, MG, PG) | <input type="checkbox"/> Melanoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Other _____ (M, F, S, MG, PG) | <input type="checkbox"/> Stomach (M, F, S, MG, PG) |
| | <input type="checkbox"/> Thyroid (M, F, S, MG, PG) |
| | <input type="checkbox"/> Uterine (M, F, S, MG, PG) |

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

Your Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed you with any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Hypotension (low blood pressure) |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Lung Disorders |
- | | |
|--|---|
| <input type="checkbox"/> Acute Respiratory Distress Syndrome | <input type="checkbox"/> Alpha-1 Antitrypsin Deficiency |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Asbestos/Dust Disease |
| <input type="checkbox"/> Bronchitis (chronic) | <input type="checkbox"/> Bronchiectasis |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Bronchopulmonary Dysplasia (BPD) |
| <input type="checkbox"/> Farmer's Lung | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Lymphangioliomyomatosis | <input type="checkbox"/> Hantavirus |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Legionellosis |
| <input type="checkbox"/> Primary Alveolar Hypoventilation Syndrome | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Pneumothorax |
| <input type="checkbox"/> Respiratory Syncytial Virus | <input type="checkbox"/> Pulmonary Alveolar Proteinosis |
| <input type="checkbox"/> Severe Acute Respiratory Syndrome | <input type="checkbox"/> Pulmonary Embolus |
| | <input type="checkbox"/> Respiratory Distress Syndrome |
| | <input type="checkbox"/> Sarcoidosis |
| | <input type="checkbox"/> Spontaneous Pneumothorax |
| | <input type="checkbox"/> Tuberculosis |
- | | |
|---|---|
| <input type="checkbox"/> Raynaud's Phenomenon | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Sinus Infections (chronic) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Wegener's Granulomatosis | <input type="checkbox"/> Other _____ |

Family Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed your family with any of the following:

- Anemia (M, F, S, MG, PG)
- Hemophilia (M, F, S, MG, PG)
- Hypertension (high blood pressure) (M, F, S, MG, PG)
- Hemorrhoids (M, F, S, MG, PG)
- HIV/AIDS (M, F, S, MG, PG)
- Hepatitis (M, F, S, MG, PG)
- Hypotension (low blood pressure) (M, F, S, MG, PG)
- Lung Disorders (M, F, S, MG, PG)

<input type="checkbox"/> Acute Respiratory Distress Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Alpha-1 Antitrypsin Deficiency (M, F, S, MG, PG)
<input type="checkbox"/> Asthma (M, F, S, MG, PG)	<input type="checkbox"/> Asbestos/Dust Disease (M, F, S, MG, PG)
<input type="checkbox"/> Bronchitis (chronic) (M, F, S, MG, PG)	<input type="checkbox"/> Bronchiectasis (M, F, S, MG, PG)
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (M, F, S, MG, PG)	<input type="checkbox"/> Bronchopulmonary Dysplasia(BPD) (M, F, S, MG, PG)
<input type="checkbox"/> Farmer's Lung (M, F, S, MG, PG)	<input type="checkbox"/> Cystic Fibrosis (M, F, S, MG, PG)
<input type="checkbox"/> Histoplasmosis (M, F, S, MG, PG)	<input type="checkbox"/> Emphysema (M, F, S, MG, PG)
<input type="checkbox"/> Lymphangiomyomatosis (M, F, S, MG, PG)	<input type="checkbox"/> Hantavirus (M, F, S, MG, PG)
<input type="checkbox"/> Pneumonia (M, F, S, MG, PG)	<input type="checkbox"/> Legionellosis (M, F, S, MG, PG)
<input type="checkbox"/> Primary Alveolar Hypoventilation Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Pleurisy (M, F, S, MG, PG)
<input type="checkbox"/> Pulmonary Fibrosis (M, F, S, MG, PG)	<input type="checkbox"/> Pneumothorax (M, F, S, MG, PG)
<input type="checkbox"/> Respiratory Syncytial Virus (M, F, S, MG, PG)	<input type="checkbox"/> Pulmonary Alveolar Proteinosis (M, F, S, MG, PG)
<input type="checkbox"/> Severe Acute Respiratory Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Pulmonary Embolus (M, F, S, MG, PG)
	<input type="checkbox"/> Respiratory Distress Syndrome (M, F, S, MG, PG)
	<input type="checkbox"/> Sarcoidosis (M, F, S, MG, PG)
	<input type="checkbox"/> Spontaneous Pneumothorax (M, F, S, MG, PG)
	<input type="checkbox"/> Tuberculosis (M, F, S, MG, PG)

- Raynaud's Phenomenon (M, F, S, MG, PG)
- Sinus Infections (chronic) (M, F, S, MG, PG)
- Wegener's Granulomatosis (M, F, S, MG, PG)
- Sickle Cell Anemia (M, F, S, MG, PG)
- Stroke (M, F, S, MG, PG)
- Other _____ (M, F, S, MG, PG)

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

Endocrine, Gastrointestinal and Neurologic Health

Check if a physician has ever diagnosed you with any of the following:

Autoimmune Disorder

<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Churg-Strauss (Allergic Granulomatosis)
<input type="checkbox"/> Eosinophilic Fasciitis	<input type="checkbox"/> Dermatomyositis/Polymyositis
<input type="checkbox"/> Goodpasture's Syndrome	<input type="checkbox"/> Interstitial Granulomatous Dermatitis
<input type="checkbox"/> Lupus	with Arthritis
<input type="checkbox"/> Lupus SLE	
<input type="checkbox"/> Lupus DLE	
<input type="checkbox"/> Lupus SCLE	
<input type="checkbox"/> Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant)	
<input type="checkbox"/> Mixed Connective Tissue Disease	<input type="checkbox"/> Relapsing Polychondritis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Sjogren's Syndrome
<input type="checkbox"/> Skin Immunofluorescence	<input type="checkbox"/> Vasculitis

Bladder Disease

Candida

Chicken Pox

Chronic Fatigue Syndrome

Crohn's Disease

Diabetes

Epilepsy

Fibromyalgia

Gall Bladder Problems

Headaches

Cluster Headaches

Migraine Headaches

Sinus Headaches

Stress-induced Headaches

Tension Headaches

Incontinence

Irritable Bowel Syndrome (IBS)

Kidney Disease

Liver Disease

Liver Problems

Measles

Mumps

Seizures

Shingles

Stomach Ulcers

Thyroid Dysfunction

Urinary Tract Infection

Other _____

Emotional and Mental Health

Check if a physician has ever diagnosed you with an emotional or mental condition. Yes

- | | |
|--|---|
| <input type="checkbox"/> Anger Disorders | <input type="checkbox"/> Anxiety Disorders |
| <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Attention Deficit Disorder with Hyperactivity (ADHD) |
| <input type="checkbox"/> Autistic Disorder | <input type="checkbox"/> Avoidant Personality Disorder (AvPD) |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Borderline Personality Disorder |
| <input type="checkbox"/> Capgras Syndrome | <input type="checkbox"/> Child Behavior Disorders |
| <input type="checkbox"/> Combat Disorders | <input type="checkbox"/> Cyclothymic Disorder |
| <input type="checkbox"/> Dependent Personality Disorder (DPD) | <input type="checkbox"/> Depressive Disorders (depression) |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Dysthymic Disorders (mood disorder) |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Firesetting Behavior |
| <input type="checkbox"/> Hypochondriasis (Somatoform Disorder) | <input type="checkbox"/> Impulse Control Disorders |
|
 | <input type="checkbox"/> Kleine-Levin Syndrome |
| <input type="checkbox"/> Kleptomania | <input type="checkbox"/> Multiple Personality Disorder |
| <input type="checkbox"/> Munchausen Syndrome | <input type="checkbox"/> Narcissistic Personality Disorder |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) |
| <input type="checkbox"/> Phobic Disorders (Phobias) | <input type="checkbox"/> Psychotic Disorders |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Seasonal Affective Disorder | <input type="checkbox"/> Sexual or Gender Disorders |
| <input type="checkbox"/> Sexual Dysfunctions (psychological, not physical) | <input type="checkbox"/> Sleep Disorders |
|
 | <input type="checkbox"/> Post-traumatic Stress Syndrome |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Suicidal Tendencies |
| <input type="checkbox"/> Other _____ | |

Sensory Health

Check if a physician has ever diagnosed you with any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cataract |
| <input type="checkbox"/> Cholesteatoma | <input type="checkbox"/> Deafness or Hearing Loss |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Laryngitis (chronic) |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Nasal Polyps |
| <input type="checkbox"/> Perforated Eardrum | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Rhinitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Unusual Vision Impairment |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Other _____ |

Musculoskeletal Health

Check if a physician has ever diagnosed you with any of the following:

Arthritis

- | | |
|---|--|
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Behets Disease |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Diffuse Idiopathic Skeletal Hyperostosis (DISH) |
| <input type="checkbox"/> Ehlers-Danlos Syndrome (EDS) | <input type="checkbox"/> Felty's Syndrome |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Infectious Arthritis |
| <input type="checkbox"/> Mixed Connective Tissue Disease (MCTD) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Paget's Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Polymyositis and Dermatomyositis | <input type="checkbox"/> Polymyalgia Rheumatica |
| <input type="checkbox"/> Reactive Arthritis | <input type="checkbox"/> Pseudogout |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Psoriatic Arthritis |
| <input type="checkbox"/> Sjogren's Syndrome | <input type="checkbox"/> Repetitive Stress Injury |
| | <input type="checkbox"/> Scleroderma |
| | <input type="checkbox"/> Stills Disease |

- | | |
|--|---|
| <input type="checkbox"/> Gout | <input type="checkbox"/> Herniated Disk |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Numbness or Tingling in feet |
| <input type="checkbox"/> Numbness or Tingling in hands | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Temporomandibular Joint Syndrome (TMJ) |
| <input type="checkbox"/> Other _____ | |

Reproductive Health

Check if you have ever given birth. Yes

How many births vaginally? _____

How many births by C-section? _____

Check if a physician has ever diagnosed you with any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Dysplasia | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Human Papillomavirus (HPV) | <input type="checkbox"/> Impotency | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Cystitis | <input type="checkbox"/> Menopause | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Testicular Dysfunction | <input type="checkbox"/> Uterine Fibroid | <input type="checkbox"/> Vaginal Yeast Infections (chronic) | <input type="checkbox"/> Other _____ |