Perry Family Practice
Jody S Velie, MD
Ally Rodgers, FNP-C
Holly Lavender, FNP-C
1016 Keith Drive, Perry, GA 31069
478-988-1515

Policies and Procedures

Thank you for choosing Perry family practice. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Perry Family Practice strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality medical care in a timely manner. Our office is pleased to have the opportunity to serve you. The following information outlines some of the policies and procedures established for this office.

When you arrive to our office for an appointment (after your initial New Patient appointment), please check in at our kiosk. If you have difficulties with the kiosk please come to the front desk sign in and have a seat. We will call you up as soon as possible. We ask you to have a seat to ensure privacy for patients. If you do not have an appointment and are walking in for labs, an injection, urine drug screen, etc. please come to the front desk, sign in and have a seat. You will be called up in the order that you’ve signed in. If you need to leave a urine sample for any reason please let the front desk know so they can direct you to the restroom.

Telephone Call Policy: Every phone call is important to us, and we will attempt to answer your calls and return your phone messages as promptly as possible. Please leave a phone number where you know we will be able to reach you. If you call for an urgent matter during office hours, we will make every effort to respond immediately. When calling the office for any reason please pick the correct extension for your needs. Some of our lines are message only lines. Please leave all important information and we will call you back or take care of the issue as soon as possible. Picking the incorrect extension could delay the process. If we are unavailable to answer the phone please leave a detailed message. Also, please do not leave multiple messages or call multiple lines with the same question/issue as this will delay our response time. Please be aware that nurses are not always available and will not leave their scheduled patients to return routine phone calls; these are generally answered after patient care sessions are finished. Again, leaving a message is the only way to know that you have called.

Good medical care cannot always be accomplished over the phone, so we may advise you to schedule an office visit to discuss your concerns, problems, or test results.

Walk-in Visits: Walk-in visits should only be used for true emergencies, as they create a scheduling problem for everyone. We ask that you please call first so we can advise you on the best approach to ensure appropriate medical care.

Appointments: Perry Family Practice is committed to providing quality care to our patients. To ensure timely continued care, we ask patients to please call to schedule appointments. We strive to schedule appointments appropriately and emergencies can occur in primary care. We kindly request your patience and understanding if a delay occurs. We encourage you to schedule appointments for preventive health, annual physicals, chronic medical conditions, prescription renewals and sick visits. Our providers have several appointment slots dedicated for same day appointments. If you are needing a same day appointment please call the office as soon as possible. We would like to remind you to leave a message if we are unable to answer the phone and we will promptly return your call. Patients arriving early for their appointments may not be taken back until their scheduled appointment time, to avoid delaying other patients unnecessarily.

Annual Wellness Visit and/or Preventive Care Visit: To clarify any confusion concerning annual preventive care visits and/or annual Medicare wellness visits. These visits include: a review of your overall health and recommended screening procedures (such as mammograms, colonoscopies and certain lab tests) and preventive measures that may be beneficial in maintaining overall good health. If you have a new medical problem that needs evaluation and requires your physician to order specific tests and/or medications and/or if you have chronic medical conditions that require supervision and surveillance and ordering of specific tests and medications, this is not included in the wellness visit and must be a separate office visit.

Cancellation of an appointment: In order to be respectful of the medical needs of our patients please be courteous and call Perry Family Practice promptly if you are unable to attend your appointment. If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance. Your early cancellation will allow another person to have access to timely medical care.

No Show Policy: A no-show is someone who misses an appointment without canceling in advance. An administrative fee of $25 will be billed to your account for a missed appointment without proper notification. *Please note that no show charges are patient’s responsibility. Most insurances will not cover them.
If you arrive late for your appointment, we will make every attempt to see you; however, your appointment may have to be rescheduled.
After Hours Contact: Non Emergent messages, please call our office and leave a message and we return your call by the next business day. These are all calls that are not emergencies.

Emergent messages (Messages that need to be taken care of IMMEDIATELY) call Dr. Velie’s cell phone @ 478-335-2752, Ally’s cell phone @ 478-396-6191 or Holly’s cell phone @478-397-0428. Please be advised these numbers should only be used for emergent messages. In the immediate Emergency, call 911 or proceed to the nearest EMERGENCY ROOM.

Weekend Contact: Dr. Velie, Ally and Holly will always have a physician covering for them if they are not on call. Call the office and dial ext. 110 to find out who the on-call physician is and their telephone number. You will need to contact this physician.

*If by chance, the message does not have the on-call physician’s name you can call the Perry Hospital and they will let you know who is on call.

*Dr. Velie only admits to and cares for patients at the Perry Hospital. If you are at any other hospital, including Houston County, another physician will be caring for you.

Insurance: We accept dozens of insurance plans with various deductibles, co-pays, and coverages. We cannot know all of the coverage limitations and rules of your plan. It is important that you read and understand the provisions of your insurance. You are responsible for ensuring that we are providers on your insurance plan and for knowing what services you have coverage for, including but not limited to office visits, labs, x-ray, procedures, physicals and immunizations. You will be responsible for paying for all services not covered by your insurance plan.

Please bring your insurance card to every visit. It is the patient’s responsibility to inform our office of any changes in insurance. Please let us know of any changes in your insurance before you are taken back for your appointment.

Payments: All co-pays and account payments are due at time of service and will be collected at each visit. We accept most major credit cards, checks and cash. Perry Family Practice will make all reasonable attempts to collect outstanding balances should they occur. If reasonable attempts to collect outstanding balances fail, accounts in poor standing will be outsourced to a third-party for the purpose of collection.

Third-Party Liability: “Third party liability” means that someone else’s insurance is to cover your illness/injury. For example, a fall at a grocery store, where the grocery store’s insurance will pay for your medical bills. We do not file charges for payment to attorneys or any other third-party payer. All charges for services rendered are payable in full at the time of your visit unless you can verify that your managed care plan will pay for the services as they would pay any other illness. You will need to submit your charges and seek reimbursement from the third-party insurance payer.

Motor Vehicle Accidents (MVA): We do not file charges for MVA insurance policies. All charges for services rendered due to a MVA are payable in full at the time of your visit unless you can verify that your managed care plan will pay for the services as they would pay any other illness. You will need to submit your charges and seek reimbursement from the MVA insurance company.

Medication refills: When you are in the office for an appointment, please let your provider know if you need refills on your medication. If you need a refill and are not in the office please contact your pharmacy. The pharmacy will send a fax or an electronic request with all the important information for your medication refill. Please allow up to 24 hours for your request. Requests should be made before you run out of your medication. The clinical staff will submit your request to your provider. Once the refill is authorized the pharmacy will be contacted. Please check the pharmacy before calling our office. If there’s a problem with your request the clinical staff will call you. If you are needing a prior authorization on a medication your pharmacy will need to fax a request for a prior authorization. Prior authorizations can take up to three business days. If you call the office about a medication please leave a detailed message and we will respond accordingly.

Urine Drug Screens: Some medications will require you to do a urine drug screen. Urine drug screen times are 11:30 to 12 (Monday through Friday) and 4 to 430 (Monday through Thursday). If you come at any other time you may have a longer wait because we are seeing patients with scheduled appointments. A co-pay will be collected for urine drug screens depending on your insurance plan.

Lab and test results: Perry Family Practice will contact you about your results. If you have not heard from us within two weeks please call the office. If we are unable to answer the phone please leave a message with all important information.

Medical records: If you are needing medical records please allow up to 30 business days to complete your request.

Medical forms: Most medical forms will require an appointment. An appointment allows the provider time to review and sign the forms. If your form does not require an appointment please allow up to 10 business days for your forms to be filled out. We will call you when your forms are ready for pick up. Examples of forms: School immunization records, Disability forms, disabled parking permits.
Office hours- Monday through Thursday 8:30am to 5pm, closed for lunch 12:15pm to 1:15pm and Friday 8:30am to 12:30pm.

To make an appointment, please call Melissa at extension 101

For medication refills, prior authorizations, referrals, pre-certs or nurse questions, please call Kristi at extension 103

For medical records, surgical clearance forms, insurance forms, X-ray, CT scan, MRI or any other test results other than labs, please call Robyn at extension 102

If you are a patient of Dr. Velie's and are inquiring about lab results, please call Kristi at extension 103

If you are a patient of Ally Rodgers or Holly Lavender and are inquiring about lab results, please call Robyn at extension 102

If inquiring about a bill from a lab company, please call Treva at extension 100

Our office billing is handled by Group One Resource billing. Please call 1-800-893-3557 with any billing or coding questions or issues.

For office hours, location and fax number, press extension 114

For doctor on-call information, press extension 110

We would also like to remind you when calling the office if we are unavailable to answer the phone please leave a message. This is the only way we know that you have called. And we will return your call as soon as possible. You can also access your patient portal for many options such as to request an appointment, lab results, medication refills, etc.

Thank you for choosing Perry Family Practice!
PATIENT INFORMATION

Patient Name __________________________ Email address: ______________________ D.O.B. ______________________

Mailing Address: _______________________ City ______ State ______ Zip __________
Street Address: ________________________ City ______ State ______ Zip __________

Home # _______________________________ Cell # __________________________ Work# __________________________

Sex: (please circle) Male / Female SSN #: __________________________

Race: ________________________________ Ethnicity: __________________________ Language Spoken: __________________________

Marital Status: (please circle one): Single Married Widowed Divorced Legally Separated

Employment Status: __________________________
Employer: ______________________________ Employer Telephone #: __________________________

Employer Address: ______________________ City ______ State ______ Zip ______

***Emergency Contacts: (please provide ALL info of at least 1 friend or 1 relative not living @ your home)***

1. Name __________________________ Relationship _______ Home # __________________________

   Cell # __________________________ Address: __________________________

2. Name __________________________ Relationship _______ Home # __________________________

   Cell# __________________________ Address: __________________________

PARENTS INFORMATION: (If pt under 18 or insurance is in parents/guardians name, please fill out the following):

Father/or Guardian __________________________ Mother/or Guardian __________________________

Name __________________________ Name __________________________

Employer: __________________________ Employer: __________________________

Employer Address: ______________________ Employer Address: __________________________

Business #: ______________________ D.O.B. ________ Business#: ________ D.O.B. ________

Home # __________________________ SSN#: __________ Home# __________________________ SSN#: __________

Insurance Information: (please fill out ALL the areas to insure the correct billing to your insurance):

*IF TRICARE: (please circle one): Tricare Standard or Tricare Prime or Tricare for Life
All Other insurances: (please circle one): HMO/POS or PPO or HRA

Primary Insurance: __________________________ Secondary Insurance: __________________________

Members Name: __________________________ Members Name: __________________________

Relationship to Patient: __________________________ Relationship to Patient: __________________________

Members SSN# __________ D.O.B. __________ Members SSN# __________ D.O.B. __________

Member ID# __________________________ Member ID# __________________________

Group# __________________________ Group# __________________________

Pharmacy: (Name, Location, and Phone Number) __________________________
HIPAA Release Form

Name: ____________________________ Date of Birth ___/___/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse__________________________
[ ] Child(ren)_______________________
[ ] Other___________________________
[ ] Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home ____________ [ ] my work ____________ [ ] my cell ____________

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] leave message with_________________________
[ ]________________________________________

Notice of Health Information Privacy Acknowledgement of Receipt

I acknowledge that I have received a copy of Perry Family Practice, LLC’s Notice of Privacy Practices. This notice describes how they may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. This information is accessible in our lobby and you may ask for a copy at any time.

__________________________________________
Signature of Patient or Personal Representative

__________________________
Date

__________________________________________
Relationship to Patient
CONSENT TO TREATMENT

I hereby authorize consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures/tests and the performance of laboratory tests, including for screening purposes, that may be considered necessary or advisable based on the judgement of the physician or their assigned designees.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to Perry Family Practice, LLC any and all rights, which I have against insurance companies or third party payers, for payment of charges for services provided by Perry Family Practice, LLC to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Perry Family Practice, LLC. If my account is placed with a collection agency, I agree to bear the cost of collection and/or court costs and reasonable legal fees, should this be required. It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service.

TCPA CONSENT – MEDICAL

You agree, in order for Perry Family Practice, LLC to service your account or to collect any amounts you may owe, our organization’s representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization’s representatives, ancillary providers, HIPAA business associates, vendors and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me as described above.

A photocopy of this consent shall be considered as valid as the original.

This consent will remain in full force until revoked in writing.

I HAVE READ THE FOREGOING CONSENT TO TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE AND TCPA CONSENT. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.

_______________________________
Borrower/Patient Signature

_______________________________
Date

_______________________________
Printed Name

_______________________________
DOB
Permission to Create a Health Exchange record and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the Central Georgia Health Exchange electronic medical record program (Health Exchange). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the Health Exchange and this permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

Printed Name of Patient/Representative: ____________________________
Signature of Patient/Representative: ____________________________
Date: ____________________________

I, ____________________________, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient):

[PROCEDURE]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other healthcare professionals, as well as hospitals and other healthcare facilities) and CGHN, through the Health Exchange electronic medical record system. Only authorized healthcare providers and their contractors, and others whose work it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The Health Exchange will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the Health Exchange to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases; diagnoses or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the Health Exchange system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the Health Exchange will be limited to only those users who have agreed to use the Health Exchange consistent with your permission. Information shared through the Health Exchange will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for healthcare services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the Health Exchange and CGHN.

You can learn more about the Central Georgia Health Exchange by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the Central Georgia Health Exchange program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the Central Georgia Health Exchange.
PATIENT NAME: ___________________________ DOB ___________________________

History of the present illness:

What is the reason for your visit today?

________________________________________________________________________

________________________________________________________________________ Do you have any problems that you would like to discuss (please list in order of importance)

________________________________________________________________________

________________________________________________________________________

Past Medical History

Please list current and past medical problems that you have been treated for:

- Blood pressure/HTN
- Cancer (please specify what type) ___________________________
- Obesity
- Thyroid disorders/Hyperthyroid
- Bleeding disorders, what type ___________________________
- Seizures
- Allergy
- Arthritis, where ___________________________
- Alcoholism
- Glaucoma, who is your eye doctor ___________________________
- High cholesterol
- Reaction to Anesthetic
- Heart trouble, what type ___________________________
- Kidney stones
- HIV or Aids
- Diabetes/DM How many times a day do you test your sugar? __________
- Stroke/CVA
- Asthma
PATIENT NAME: ___________________________  DOB ___________________________

Other illnesses or Medical Problems:  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Physician who treated you:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Past surgical history
*Please list your previous surgeries, and the year and the hospital:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Current Medications: Please list all medications you are now taking, including those you buy without a doctor’s prescription, including nutritional supplements, and/or herbal medicines.

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Allergies and Sensitivities (list any allergies to medications)

Allergic To:  
Reaction:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you ever reacted to anesthetic?  Yes  No
PATIENT NAME: ________________________  DOB ________________________

Immunizations—Please list date of testing also

Tetanus booster __________________________ recommended every 10 years

Pneumovax (Pneumonia) __________________________ recommended for age 65 +

Hepatitis B Vaccine __________________________ required for school-aged children, optional for Adults

Skin test for TB __________________________ Was it positive or negative

Recommended for high risk individuals and

Influenza Vaccine __________________________ Healthcare workers

Social History

Marital status:  SINGLE  MARRIED  WIDOWED  DIVORCED

Number of children: __________________________

Occupation: __________________________ Are you currently employed? __________________________

Any occupational hazards (noise or chemical exposures)?  Yes  No

If yes, please describe: __________________________

Education: (last grade completed) __________________________

Religious affiliation? YES  NO  If yes, what is your affiliation? __________________________

Nutritional History

Have you recently gained or lost weight (more than 10 lbs) in 1 month without wanting to? YES  NO

If yes, how much weight gain or loss? (SPECIFY GAIN OR LOSS) __________________________

Are you happy with your weight? __________________________

For women, are you taking any extra calcium? YES  NO
PATIENT NAME: ___________________________  DOB _________________________

Habits and Safety

Are you very active, or get regular exercise?  YES  NO

Do you currently smoke?  YES  NO

If so, how many packs a day? ___________  How many years? ________________

If not, are you a former smoker?  Yes  NO

Do you drink alcoholic beverages?  YES  NO

If yes, amount per week: _______________

Have you ever used recreational drugs?  YES  NO

If yes, please specify type i.e. marijuana, cocaine, heroin, intravenous drugs:

________________________________________

Review of Symptoms: Please check each symptom that you have now or have had in the past three months:

General (Male & Female)

- Fever
- Chills
- Fatigue
- Night Sweats
- Weakness

Musculoskeletal (Male & Female)

- Decreased range of motion
- Joint Pain
- Joint Stiffness
- Joint Swelling
- Back pain
- Muscle Pain

Breasts (Male & Female)

- Lumps in breasts
- Discharge from nipple

*Date of last mammogram: _______________
PATIENT NAME: ___________________________ DOB ___________________________

Vaginal & Urinary (Female)

- Vaginal itching or burning
- Vaginal discharge
- Sexual difficulties
  *If so, please list:

- Pregnancy, #________
- Hot flashes
- Problems w/ menstrual periods

*Date of last menstrual period _______________________

*Date of last pap smear ________________

Who is your OBGYN? _______________________

Painful menstrual cycle: NO  YES

Irregular menstrual cycle: NO  YES

Heavy menstrual cycle: NO  YES

Methods of contraception: (list below)

________________________________________
________________________________________

Sexually transmitted disease(s): (please specify)

________________________________________
________________________________________

Urology (Male & Female)

- Painful or frequent urination (please specify which) ____________
- Previous urinary infections
- Kidney stones
- Blood in urine
- Incontinence
PATIENT NAME: __________________________ DOB __________________________

Genital and Urinary (Male)
- Hernia
- Pain or lump in testicles
- Obstructive symptoms
- Incontinence (leaking)
- Frequent Urination at night
- Difficulty with Erection
- Diminished Sexual Drive
- Discharge from penis

*Date of last prostate exam and/or PSA : __________
*Sexually transmitted disease(s), please specify below: __________________________________________

Eyes (Male & Female)
- Glasses or contacts
- Change in Vision
- Eye Drainage
- Eye Irritation
- Eye pain
- Eye Redness
- Loss of Vision

*date of last eye exam __________________

Ears, Nose, Sinuses, Mouth & Throat (Male & Female)
- Ear Pain
- Sneezing
- Ringing in Ears
- Hearing Loss
- Dizziness
- Nasal Congestion
- Post-nasal Drip
- Runny Nose
- Sinus Pain
- Nosebleed
- Dentures
- Toothache
- Sore Throat
- Hoarseness
- Snoring
- Swollen Lymph Nodes

*date of last dental exam: __________________
PATIENT NAME: ____________________________  DOB ____________________________

Lungs (Male & Female)

- Shortness of breath
- Cough
- Wheezing
- Spitting Up Blood
- Difficulty breathing at night

Heart (Male & Female)

- Chest pain
- Palpitations (heart pounding)
- Ankle Swelling
- Trouble breathing at night

Skin (Male & Female)

- Change in warts, moles, or birthmarks
- Itching
- Rash
- Lumps
- Acne

Hematologic & Lymphatic (Male & Female)

- Easy bruising or bleeding problems
- Swollen lymph nodes

Gastrointestinal (Male & Female)

- Bloating/belching
- Difficulty Swallowing
- Heartburn/Indigestion
- Abdominal Pain
- Nausea
- Vomiting
- Change in Bowel Habits
- Constipation
- Diarrhea
- Blood in Stool
- Hemorrhoids

*Date of last colonoscopy: ____________________________  *who performed this test? ____________________________
Nervous system (Male & Female)

- Head Injury
- Passing Out
- Headache
- Weakness
- Tingling/Numbness
- Speech Abnormality
- Dizziness
- Memory Loss
- Seizures
- Balance or coordination loss

Endocrine (Male & female)

- Increased Urination
- Always thirsty
- Always Hungry
- Weight Loss
- Weight Gain
- Sleep disturbances
- Excess Cold
- Excess Hot
- Skin Change
- Hair Change
- Bowel Change
- Palpitations

Psychological (Male & Female)

- Mood Swings
- Panic Attacks
- Depression
- Anxiety
- Sleep Disturbances
PATIENT NAME: ____________________________  DOB ____________________________

Pain Screening

Do you have pain now?  NO  YES

Do you have on-going pain problems?  NO  YES

If yes, for how long? __________________________

**If you answered yes to questions above please continue with questions below:

Location: ____________________________  Intensity (0 to 10): Now _____  Usual _____

On a 0 to 10 scale, what is your level of pain when it is at its best? ______

On a 0 to 10 scale, what is your level of pain when it is at its worst? ______

On a 0 to 10 scale, at what level of pain are you able to function as you want? ______

Describe your pain (burning, aching, stabbing, dull, crushing): __________________________

What causes or increases your pain? ________________________________________________

What do you do to relieve your pain? ______________________________________________

What medication(s) do you take for pain? ____________________________________________

Are you satisfied with your pain control?  NO  YES
**PATIENT NAME:** __________________________  **DOB** __________________________

**Family History:** Have any members of your family had any of the following conditions?

****Please specify relationship i.e. grandmother, grandfather, mother, father, brothers, sisters, uncles, aunts, son or daughter. Specify living status i.e. living/deceased/unknown for each person listed and their year of birth.****

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Family Relationship</th>
<th>Living Status</th>
<th>Year of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAD/heart attack</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVA/stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing deficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney/Renal disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SIGNATURE OF PATIENT/LEGAL GUARDIAN:** __________________________________________

**DATE:** __________________________