DISC & SPINE

# PATIENT REGISTRATION FORM

**RR □ VT □**

**Patient Name:_____**

Date of Birth: _____ Social Security #: _____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other (*please specify*): _____

Primary Language: _____

Mailing Address: _____ Apt/Suite #: _____

City _____ State _____ Zip code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Text Appointment Confirmation: □ YES □ NO

Email Address: _____Email Appt. Confirmation: □ YES □ NO

Preferred Method of Contact: □ Home □ Cell □ Work

**PRIMARY CARE PHYSICIAN**: _____ Phone No.: _____

**REFERRED BY:** _____

## EMPLOYMENT:

Employer's Business Name: _____ Occupation: _____

Current Status: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Retired ☐ Unemployed ☐ Student

***RESPONSIBLE PARTY INFORMATION:***

*Complete if patient is 17 or younger. Any legal guardian/parent presenting a minor patient for medical services is considered financially responsible for services rendered. Any minor patient accompanied by an adult other than their legal guardian/parent must present written and notarized authorization for medical treatment from the legal guardian/parent prior to services being rendered.*

Full Name: _____ Social Security #: _____

Relation to patient: _____ Date of Birth: _____

Address (if different from above): _____

Phone Number: _____ Employer: _____

**EMERGENCY CONTACT***: Are we authorized to speak to your emergency contact regarding your medical record and treatment?* : YES ☐ NO ☐

Full Name: _____ Relation to patient: _____

Phone Number: _____ City, State: _____

## HOW WILL THE SERVICE BE PAID?

☐ Private Insurance ☐ Worker's Compensation ☐ Self-pay (NO Insurance)

☐ Other (need complete documents): _____

**Patient/Guardian Signature: _____**

**Today's Date: _____**

DISC & SPINE

# INSURANCE INFORMATION

**Patient Name: _____**

## PRIMARY INSURANCE:

Insurance Company Name: _____ ☐ PPO ☐ HMO ☐ EPO

Address: _____

Subscriber's ID #: _____ Policy or Group #: _____

- *If Policyholder/Subscriber for Primary Insurance is different from patient, please answer below.*

Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN: _____ Phone: _____

Complete Address: _____

Employer (*if issued through employment*): _____

## SECONDARY INSURANCE:

Insurance Company Name: _____ ☐ PPO ☐ HMO ☐ EPO

Address: _____

Subscriber's ID #: _____ Policy or Group #: _____

- *If Policyholder/Subscriber for Secondary Insurance is different from patient, please answer below.*

Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN: _____ Phone: _____

Complete Address: _____

Employer (*if issued through employment*): _____

***DO YOU HAVE AN ATTORNEY?*** ☐ YES ☐ NO

Attorney Name: _____ Phone Number: _____

Address: _____ Law Firm? _____

**Should this attorney have access to all of your records?** ☐ **YES** ☐ **NO**

## WORK RELATED INJURIES:

Date of Injury: _____ Claim Number: _____

Worker's Compensation Carrier: _____

Address: _____

Claim Adjuster's Name: _____ Phone Number: _____

FAX: _____ **Do you require an interpreter?** ☐ **Yes** ☐ **No**

Employer at time of Injury: _____

Supervisor's Name: _____ Phone Number: _____

**Patient/Guardian Signature: _____**

**Today's Date: _____**

**Disc and Spine a partnership of**

**Robert A. Rovner MD, A Professional Corporation and Vikram Talwar MD Incorporated**

# NOTICE OF PRIVACY PRACTICES

**This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

## Our Pledge Regarding Your Health Information

We understand that information about you and your health is personal. We are both committed to, and required by law to, maintain the privacy of this information. Each time we provide services, we create a record of the care and services you receive. We need this record to provide quality care and to comply with certain legal requirements. This notice applies to all of your information and the records of your health care generated by us or received by us from you or others.

Along with safeguarding your personal health information, we must also make available this notice of our legal duties and privacy practices, and we must follow the terms of the notice currently in effect. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights of access, amendment, control, and other rights concerning the use and disclosure of your health information. Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. is also required to notify you if your health information is breached.

If you are the parent, legal guardian, or personal representative of the patient, the references herein such as "...your personal health information..." shall be understood to refer to that patient.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with us, directly to our Privacy Officer: Vanessa Chaplin, Disc and Spine, 1320 El Capitan Drive, Suite 200, Danville CA 94526, Phone: (925)275-0700, Fax: (925)275-0701 You can also file a complaint with the Secretary of the Department of Health and Human Services at www.hhs.gov or in writing to any regional HHS office. There will be no retaliation for filing a complaint.

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## How We May Use and Disclose Your Health Information

The following categories describe different ways that we may USE your health information within Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc., and DISCLOSE your health information to persons and entities outside of Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. We have not listed every use or disclosure within the categories, but give some examples for understanding.

## Common Uses and Disclosures Allowed by Law

**Treatment:** We may use your health information to provide you treatment and services. We may disclose health information about you to others who are involved in your care.

**Payment:** We may use and disclose your health information so the treatment and services you receive at Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. may be billed to and payment collected from you, an insurance company or a third party. We may also disclose health information to your insurance plan to obtain prior authorization for treatment and procedures.

**Health Care Operations:** We may use and disclose your health information for health care activities such as: quality assurance; administration; Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. financial and business planning and development; and customer service (including investigation of complaints). These uses and disclosures are necessary to operate our health care facility and make sure patients receive quality care.

**Business Associates:** Some services may be provided to our organization through contracts with business associates, such as: practice consultants; quality assurance reviewers; and billing and transcription services. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. Business associates are required, both legally and contractually, to appropriately safeguard your information.

**Contacting You About Your Health:** We may use and disclose health information to contact you, such as a reminder about an appointment or other treatment options at Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc.

**Fundraising:** If we are going to contact you as part of a fundraising effort, you will have a simple way to opt out of these contacts.

**Individuals Involved in Your Care:** We may disclose health information about you to a friend or family member who is involved in your care, unless you tell us in advance not to do so.

**Other Laws:** At times there may be federal, state or local laws that require us to use or disclose health information in other ways, or give you additional privacy protections. We will obey those laws.

## Certain Situations Do Not Require Your Authorization

The following disclosures of your health information are permitted by law without any oral or written permission from you:

**Public Health Activities:** We may disclose health information about you for public health activities, including:

* To prevent or control disease, injury or disability.
* To report births and deaths.
* To report child abuse or neglect.
* To report reactions to medications, problems with products or other adverse events.
* To notify people of recalls of products they may be using.
* To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

* To avert a serious threat to you or others. These disclosures would be made only to someone able to intervene.
* To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence.
* Immunization records to a school requiring such for entry, provided informal approval is given by a parent, guardian, or the patient if the patient is an adult or emancipated minor.
* To Disaster Relief agencies (such as the Red Cross) for notification as to your location and condition.
* If you are an organ donor, we may release health information to the organizations that handle the process, as necessary to facilitate the donation.

**Military and Veterans:** If you are a member of the armed forces, we may release health information about you as required by military command authorities.

**Worker's Compensation:** We may release health information about you for worker's compensation or similar programs if you have a work related injury.

**Health Oversight Activities:** Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. may disclose health information to a health oversight agency for activities authorized by law. These include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may be required to disclose your health information in response to a court order, administrative order, subpoena, discovery request or other lawful process by someone involved in the dispute.

**Law Enforcement:** We may disclose health information to law enforcement officials for reasons such as:
* In response to a court order, subpoena, warrant, summons or similar process.
* To identify or locate a suspect, fugitive, material witness or missing person.
* About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
* About a death we believe may be the result of criminal conduct.
* About criminal conduct at our facility.
* In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Health Records of Deceased Patients:** We may disclose health information to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral home directors as necessary to carry out their duties. We may disclose to relatives or close personal friends who were involved with the patient's care prior to death, health information relevant to their involvement. HIPAA privacy protections continue until 50 years after the patient's death.

**National Security and Intelligence Activities:** We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**Legal Requirements:** We will disclose health information about you without your permission when required to do so by federal, state or local law.

## Other Uses and Disclosures Require Your Authorization

Other uses and disclosures of health information not covered by this notice or applicable laws will be made only with your written permission (called "authorization"). If you do give authorization in some instances, you may revoke that authorization in writing at any time. Uses and disclosures of your personal information that require your authorization include marketing functions, and most disclosures that involve sale of health information. Your authorization is also required before we can use or disclose psychotherapy notes about you for any purpose other than basic treatment and healthcare operations.

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## Your Health Information Rights

You have the following rights concerning your health information:

**1. Request a restriction on certain uses and disclosures of your information.** We may agree to your request but are not required by law to do so, with the one following exception (item 2)...

**2. Restricting disclosures to health plan or insurance for treatment you pay for in full.** (The one exception to item 1 above) If you pay in full at the time of service and request we not disclose the information to your health plan or insurer, we must and will comply.

**3. Obtain a copy of this Notice of Privacy Practices upon request.**

**4. Inspect and/or request a copy of your health record.** You must make the request in writing, and we have 30 days to comply.

**5. Request an amendment to your health record** if you feel the information is incorrect or incomplete. Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. may deny your request if, for instance, we believe it is accurate and complete as it stands.

**6. Obtain an accounting of disclosures of your health information.** This will include the times when someone used or disclosed your health information other than the allowed common uses and disclosures, or uses and disclosures that you authorized.

**7. Request communication of your health information by alternative means or locations.** For instance: an address or phone number other than your home.

**8. Revoke a previously agreed upon authorization** except to the extent that action has already been taken.

**For more information contact our privacy officer:** Vanessa Chaplin, Disc and Spine, 1320 El Capitan Drive, Suite 200, Danville CA 94526, Phone: (925)275-0700, Fax: (925)275-0701, Email: appointments@discandspine.com.

**We reserve the right to change this notice**, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. A copy of the current notice in effect will be available at Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc.

Effective Date: 8/18/2018

# Acknowledgment of Receipt

## Disc and Spine a partnership of

## Robert A. Rovner MD, A Professional Corporation and Vikram Talwar MD Incorporated

## NOTICE OF PRIVACY PRACTICES

By signing this page you acknowledge that you have received a copy of our Notice of Privacy Practices.

Print Name of Patient _____

Signature of Patient _____
(or Personal Representative)

Print Name of Personal Representative _____
(if NOT Patient)

Date Signed _____

Witnessed by _____

Effective Date: 8/18/2018

DISC & SPINE

1320 El Capitan Drive #200
Danville, California 94526
Phone: 925-275-0700
Fax: 925-275-0701

**Robert A. Rovner, MD, A Professional Corporation**
*Diplomate American Board of Orthopedic Surgery*
*Fellow American Academy of Orthopedic Surgery*

**Vikram Talwar, MD, Incorporated**
*Diplomate American Board of Orthopedic Surgery*
*Fellow American Academy of Orthopedic Surgery*

**Patient Name:** _____ **Date of Birth:** _____

# Financial Policies

**Assignment of Benefits and Release of Information** I hereby assign insurance benefits to be paid directly to Dr. Rovner or Dr. Talwar for medical and surgical services rendered to me. I hereby authorize the release of medical information to insurance carriers.

**Patient Responsibility (with medical insurance coverage)** I understand that I am financially responsible for charges not covered by my insurance benefits, workers compensation carrier, or liability insurance. Office visit co-payment is due and payable at time of service.

**Patient Responsibility (self-pay patients)** I understand payment for all services are due at the time services are rendered.

**Financial Guarantee** I guarantee that in consideration of services rendered by the physicians, Dr. Rovner or Dr. Talwar, I will be personally responsible for any and all expenses incurred for such treatment. Also, I agree to pay all collection agency fees, attorney's fees, and court costs.

**Credit Card Information** We accept the following credit cards: Visa MasterCard, Discover, or American Express. Debit cards are accepted for all banks. The minimum charge amount for American Express is $20.00.

**No-Show Policy** There will be a $**40.00** No-Show charge assessed for appointments that are not cancelled within a 24-hour period prior to the appointment date/time.

**Form Fee Policy** I am aware that there is a $**25.00** fee for the completion of all forms <u>except</u> State of California Employment Development Department (disability). This fee is due before the completion and release of the form to me.

**Non-Sufficient Fund (NSF) Policy** I acknowledge that there is a $**25.00** bank and processing fee in addition to the original check amount that will be assessed.

**Radiology Image Copies** There will be a **$10.00** fee for all CD copies of images taken in other facilities i.e. MRIs, CTs. On all in house X-Ray imaging, the first CD is complimentary, a **$10.00** will apply for additional copies.

**Preferred Provider Plans** With certain insurance companies, it is necessary for you to be treated by a Preferred Provider to ensure complete coverage. If the doctor is not on the preferred provider panel, you will be responsible for the charges. Please check with your insurance carrier or our office for verification before being seen.

**Medicare** We accept assignment with Medicare. One secondary insurance claim is submitted as a courtesy.

**Non-Contracted Plans and/or Motor Vehicle Claims** We will submit one insurance claim as a courtesy, provided that a current insurance card is presented at your visit OR we have proof of your personal injury coverage.

**Third Party Claims** We do not bill third party claims.

**HMO Insurance Plans** A referral is required from your primary care physician prior to each appointment. If we do not have a referral at the time of your appointment, your signature/initials acknowledge that you will be responsible for any charges incurred without a referral/authorization.

**Durable Medical Equipment** During your visit, durable medical equipment such as neck or back braces may be ordered and dispensed. If you have health insurance, those items will be pre-authorized prior to being dispensed. These charges may be reflected on your statement.

**Signature of Patient or Guarantor:**

_____ Date: _____

**Print Patient Name:**

_____

DISC AND SPINE ROBERT ROVNER, MD - VIKRAM TALWAR, MD- NEW PATIENT HEALTH QUESTIONNAIRE

Full Name:_____Date of Birth:_____

Date of Visit:_____

Height:_____ Weight:_____ Age:_____

**TODAY'S VISIT**

**What is the reason for your visit today / chief complaint?**

**Was this MVA related?** ☐Yes ☐ No **Work-related injury?** ☐Yes ☐ No **Date of onset:** _____

**Do you need a work note or forms completed?** ☐Yes ☐ No
Form/note type:

**How often does the pain/numbness occur:** ☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent ☐ N/A

**What is the status of your condition since the onset date:**
☐ Unchanged ☐Improving ☐Fluctuating ☐Stable ☐Worse ☐ Resolved

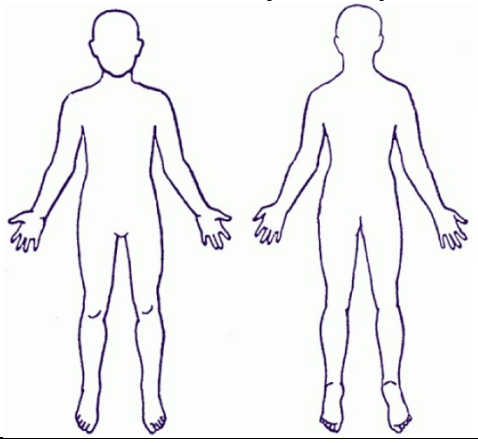
**What is the severity of your pain / numbness?** (circle a number)
**No Pain -- 0 1 2 3 4 5 6 7 8 9 10 -- Incapacitating**

**Where type of pain/ numbness are you experiencing?** Check all that apply ☐ No pain/numbness
☐ Ache ☐ Burning ☐ Deep ☐ Superficial ☐ Dull ☐ Localized ☐ Piercing
☐ Sharp ☐Shooting ☐ Throbbing ☐ Electric ☐ Tingling ☐ Numb ☐ Discomfort

**What is the location of your pain/numbness?** Check all that apply ☐ No pain/numbness

| | | | | | |
|---|---|---|---|---|---|
| ☐ Neck | ☐ Upper back | ☐ Mid back | ☐ Lower back | ☐ Gluteal area | ☐ Flank |
| ☐ Thighs | ☐ Legs | ☐ Shoulder | ☐Arm | ☐ Hand | ☐ Fingers |
| ☐ Other:_____ | (circle one) RT / LT / Both | (circle one) RT / LT / Both | (circle one) RT / LT / Both | (circle one) RT / LT / Both | (circle one) RT / LT / Both |

**Below "X" the areas you feel pain**



**Circle which best describes your pain:**

Full Name:_____Date of Birth:_____

**What aggravates your condition?** Check all that apply ☐ Nothing aggravates my condition
☐ Daily activity ☐ Ascending stairs ☐ Descending stairs ☐Coughing ☐ Driving
☐ Flexion ☐ Extension ☐ Lifting weight ☐ Rotating/twisting ☐ Bending ☐ Standing
☐ Sitting ☐ Walking ☐ Exercise ☐ Lying down/sleep ☐ Other:_____

**What relieves your condition?** Check all that apply ☐ Nothing relieves my condition
☐ Ice ☐ Heat ☐ Elevation ☐Mobility ☐ Rest ☐ Stretching ☐ Exercise ☐ Brace
☐ Massage ☐ Physical therapy (how many visits completed):_____ ☐ Acupuncture ☐ Chiropractic
☐ Injection ☐ OTC meds (which med):_____
☐ Pain medication (which med):_____
**Pain level after taking your medication: No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating**

**Anything else you would like addressed in your appointment today:**

**PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including OTC)**

☐ **No medications to list** ☐ **See attached medications list**
**Are you taking blood thinners? ☐ Yes ☐ No**

| Medication Name | Dose | Purpose | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**DRUG & OTHER ALLERGIES (list):**
☐ **NO KNOWN DRUG ALLERGIES**

**Have you had a fall in the last 12 months?** ☐Yes ☐ No **More than 2 times?** ☐Yes ☐ No

**SOCIAL HISTORY**

Occupation:_____ Employer:_____Still employed?☐Yes ☐ No
Marital status:_____Do you exercise?☐Yes☐ No If yes, how often?:_____
**Do you smoke tobacco products?** ☐Yes ☐ No If yes, have you ever tried to quit? ☐Yes ☐ No
Type:_____ Packs per day:_____ Years used:_____
**Do you drink alcohol?** ☐Yes☐ No If yes, how many drinks per week?_____
Have you traveled or lived outside the US or Canada? ☐Yes☐ No If yes, when/where:_____

Full Name:_____Date of Birth:_____

| PAST MEDICAL AND FAMILY HISTORY | | | |
|---|---|---|---|
| **Illness/Condition** | **Self** | **Relative** | **Describe** |
| Anesthesia complications | ☐Yes ☐ No | ☐Yes ☐ No | |
| Bleeding prob/blood clots | ☐Yes ☐ No | ☐Yes ☐ No | |
| Cancer | ☐Yes ☐ No | ☐Yes ☐ No | |
| Diabetes | ☐Yes ☐ No | ☐Yes ☐ No | |
| Heart disease | ☐Yes ☐ No | ☐Yes ☐ No | |
| Hepatitis/HIV | ☐Yes ☐ No | ☐Yes ☐ No | |
| Liver disease | ☐Yes ☐ No | ☐Yes ☐ No | |
| Psychiatric illness | ☐Yes ☐ No | ☐Yes ☐ No | |
| Stroke/TIA | ☐Yes ☐ No | ☐Yes ☐ No | |
| Tuberculosis | ☐Yes ☐ No | ☐Yes ☐ No | |
| Other: | ☐Yes ☐ No | ☐Yes ☐ No | |

| DIAGNOSTIC HISTORY ☐ None | | |
|---|---|---|
| **Study** | **Date** | **Results** |
| **X-rays** | | |
| **MRI/CT** | | |
| **EMG/nerve conduction studies** | | |
| **Myelogram** | | |
| **Bone scan/DEXAscan** | | |
| **Other:** | | |

| PAST TREATMENTS RELATING TO CURRENT PROBLEM(S) ☐ None | | | | |
|---|---|---|---|---|
| **Treatment** | **Start Date** | **End Date** | **Provider** | **% of relief 0-100** |
| **Activity modification** | | | | |
| **Bracing** | | | | |
| **Injection/nerve block** | | | | |
| **Drug/medications** | | | | |
| **Physical therapy** | | | | |
| **Chiropractic** | | | | |
| **Acupuncture** | | | | |
| **Home exercise** | | | | |
| **Other:** | | | | |

| PRIOR SURGERY ☐ None | | | | |
|---|---|---|---|---|
| **Name of Operation** | **Reason** | **Date** | **Facility** | **Physician** |
| | | | | |
| | | | | |
| | | | | |

Full Name:_____Date of Birth:_____

## REVIEW OF SYSTEMS

**CHECK IF YOU HAVE ANY OF THE FOLLOWING** ☐ **ALL NEGATIVE BELOW**

**Constitutional**
- ☐ Fever/chills/night sweats
- ☐ Weakness/fatigue
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other:_____

**Cardiovascular**
- ☐ Stroke/blood clots
- ☐ Chest pain
- ☐ Abnormal heart rhythm
- ☐ High blood pressure
- ☐ Heart problem:_____
- ☐ Other:_____

**Integumentary**
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesions
- ☐ Other: _____

**Ear, Nose, Throat & Eyes**
- ☐ Eye/vision disorders
- ☐ Frequent sore throat
- ☐ Vertigo/dizziness
- ☐ Voice hoarseness
- ☐ Difficulty swallowing
- ☐ Other: _____

**Gastrointestinal (GI)**
- ☐ Constipation/diarrhea
- ☐ Liver/gallbladder issues
- ☐ Nausea/vomiting
- ☐ Ulcers
- ☐ Heartburn/reflux
- ☐ Black or bloody stool
- ☐ Other: _____

**Neurological**
- ☐ Diff. walking/balance
- ☐ Dizziness
- ☐ Seizures
- ☐ Headache
- ☐ Weakness/numbness
- ☐ Neurologic problem
- ☐ Other: _____

**Respiratory**
- ☐ Lung issues:_____
- ☐ Recent cold/flu
- ☐ Wheezing/asthma
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Abnormal chest x-ray
- ☐ Other: _____

**Genitourinary**
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Kidney disease
- ☐ Bladder leakage
- ☐ Other: _____

**Psychiatric**
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Mood disorder
- ☐ Other:_____

**Allergic/Immunologic**
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Hives/Eczema
- ☐ Autoimmune disorder
- ☐ Other:_____

**Musculoskeletal**
- ☐ Arthritis/osteoporosis
- ☐ Broken bones
- ☐ Joint pain/swelling
- ☐ Carpal tunnel
- ☐ Other:_____

**Endocrine**
- ☐ Diabetes – I or II
- ☐ Parathyroid/Paget's
- ☐ Heat/cold intolerance
- ☐ Thyroid disorder
- ☐ Other:_____

**Hematology/Lymphatic**
- ☐ Easy bruising/bleeding
- ☐ Enlarged glands
- ☐ Anemia
- ☐ Blood transfusions
- ☐ Other:_____

**Females Only**
- ☐ Pregnant
- ☐ Last menstrual period: _____

**Other:**

***FOR STAFF USE ONLY:*** Pulse:_____ BP:_____ BMI:_____

Oriented x 3: ☐ Awake ☐ Responsive ☐ Oriented to person/place/time

_____ _____

Patient Signature (Date) MD/ PA Signature (Date)