***Welcome To Our Practice***

**Patient Information**

Name (Last, First, MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec: #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M[ ] F[ ]

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE REQUIRED ETHNICITY AND RACE QUESTIONNAIRE

Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone Numbers**

Home (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Mobile (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.com

**Marital Status:** [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Life Partner

**Emergency Contact**

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

Primary number (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Secondary number (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

\*Primary insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Secondary insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Information**

Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address/Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Fax number (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL CARE INFORMATION**

**(Healthcare Providers or Facility)**

Name (Last, First MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec: #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M[ ] F[ ]

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to release copies of my medical records concerning any

(Name of other Provider/Facility)

Illness, Treatment or recommendations while I was patient of the above listed medical Facility or Physician(s).

I understand that my medical records may contain copies of Information received from another health care facility or physician(s). I also understand that the above information may contain reference results (AIDS) antibody testing, testing or treatment of communicable diseases, treatment for mental health problems, alcohol history, or substance abuse, and I authorize the release of such confidential information to the indicated party.

Information to be released:

\_\_\_\_\_ Chart Note \_\_\_\_\_ Labs \_\_\_\_\_\_X Rays

\_\_\_\_\_ Procedure \_\_\_\_\_ Medication \_\_\_\_\_\_ ALL RECORDS

**FAX TO: *STONE OAK GASTROENTEROLOGY***

**Attn: Medical Records**

**19284 Stone Oak Pkwy #102**

**San Antonio, TX 78258**

**Phone: (210) 268-0124**

**Fax# (210) 268-0146**

For the Purpose of: *CONTINUITY OF CARE*

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

Patient Signature Date

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

**(Family and/or Friend)**

In accordance with the HIPAA law, it is required that you provide our office with the name of any person to whom you want the release of your personal health records; via over the phone, by fax, or e-mail. This does N**OT** include other healthcare providers you see.

I hereby give permission for the following parties mentioned below to obtain information in regards to my medical records at Stone Oak Gastroenterology.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   **NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER**
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   **NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER**
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   **NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER**
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   **NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER**
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   **NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**SIGNATURE OF PATIENT/GUARDIAN PRINTED NAME DATE OF SIGNATURE**  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**SIGNATURE OF POWER OF ATTORNEY PRINTED NAME DATE OF SIGNATURE** (IF APPLICABLE)

**PROCEDURE CANCELLATION POLICY**

When a procedure appointment is scheduled with us, we reserve a block of time especially for you. In that situation, it will include the MD, an anestheisologist, and multiple RN’s, which all charge for time, irrespective of whether you show up or not. If you do not appear for your procedure, that block of time is unavailable to someone else who is waiting for our care.

We require a **2 BUSINESS DAYS** to cancel or reschedule a procedure.

If you fail to give the required notice in the allotted time, you will be subject to a fee that will not be covered by your insurance.  
  
Some examples of cancellation fees are as follows:

|  |  |
| --- | --- |
| OFFICE VISIT | $50 CANCELLATION FEE |
| ALLERGY APPOINTMENT | $75 CANCELLATION FEE |
| COLONOSCOPY/ENDOSCOPY APPOINTMENT | $200 CANCELLATION FEE |
| CAPSULE ENDOSCOPY | $200 CANCELLATION FEE |

\*\*\* Please give 2 business day notice to avoid fee \*\*\*

Patients will only be exempt from the cancellation fee on emergency situations **ONLY**, i.e. **case-by-case basis**.

**Please sign stating that you have read and understand our Procedure Cancellation Policy**.  
  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**SIGNATURE OF PATIENT/GUARDIAN DATE OF SIGNATURE**

**CONSENT OF UNDERSTANDING ON PATIENT RIGHTS AND PRIVACY NOTICE**

I have read the Privacy Notice and understand my rights as a patient contained in the Notice.

By way of my signature, I provide **STONE OAK GASTRONTEROLOGY** with my authorization and consent to use and disclose my protected healthcare information, PHI, for the purposes of treatment, payments, and healthcare operations as described in the Privacy Notice. A copy is available to take upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**SIGNATURE OF PATIENT/GUARDIAN PRINTED NAME DATE**   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**AUTHORIZED FACILITY SIGNATURE PRINTED NAME DATE**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRING MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR TODAY’S VISIT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **LIST OF SYMPTOMS** | | | | | | |
|  | **WHEN DID IT START?** (# of days ago, months, etc.) | **HOW OFTEN?** (Constant, daily, weekly, monthly, etc.) | **TIME OF DAY?** (AM/PM or N/A) | **RELATED TO DIET?** (Describe or N/A) | **SEVERITY**  (1-10 PAIN LEVEL) | **ADDITIONAL DESCRIPTION(S)?** |
| Right-Upper Abdomen Pain |  |  |  |  |  | **Radiates to back?  Y / N** |
| Right-Lower Abdomen Pain |  |  |  |  |  |  |
| Left-Upper Abdomen Pain |  |  |  |  |  |  |
| Left-Lower Abdomen Pain |  |  |  |  |  |  |
| Other Abdominal Pain: \_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
| Diarrhea |  |  |  |  |  |  |
| Constipation |  |  |  |  |  |  |
| Fecal leakage |  |  |  |  |  |  |
| Hemorrhoids |  |  |  |  |  |  |
| Rectal Pain |  |  |  |  |  |  |
| Rectal Bleeding |  |  |  |  |  |  |
| Black/Tarry Stool |  |  |  |  |  |  |
| Nausea |  |  |  |  |  |  |
| Vomiting |  |  |  |  |  | **Bloody Emesis?  Y / N** |
| Sour Taste in Mouth |  |  |  |  |  |  |
| Excessive Belching |  |  |  |  |  |  |
| Heartburn |  |  |  |  |  |  |
| Acid Reflux/Regurgitation |  |  |  |  |  |  |
| Sore Throat |  |  |  |  |  |  |
| Difficulty Swallowing |  |  |  |  |  | **FOODS SALIVA LIQUIDS PILLS** |
| Sensation something is stuck in throat |  |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |

**FAMILY MEDICAL HISTORY**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PLEASE MARK THE APPROPRIATE BOX TO INDICATE WHICH MAY APPLY. IF NONE APPLY, MARK IN THE “HISTORY UNKOWN/NONE” FIELD.** | COLORECTALCANCER | COLORECTAL POLYPS | STOMACH CANCEER | CROHN’S DISEASE | ULCERATIVE COLITIS | PANCREATIC CANCER | LIVER CANCER | HEPATITIS | CIRRHOSIS | OVARIAN CANCER | PROSTATE CANCER | BREAST CANCER | UTERINE CANCER | OTHER CANCERS | HEART DISEASE | STROKE | **HISTORY UNKNOWN/NONE** |
| MOTHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| FATHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SISTER(S) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| BROTHER(S) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL G.M. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL G.F. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERANAL G.M. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL G.F. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**MEDICAL HISTORY (CONTINUED)**

|  |  |  |
| --- | --- | --- |
| **SURGERIES/PROCEDURES** | **DATE OF SERVICE** | **HABITS** |
|  |  | **SMOKING**:  PACKS DAILY: \_\_\_\_\_\_\_\_\_\_ # OF YEARS SMOKING: \_\_\_\_\_\_\_\_\_\_ # OF YEARS AGO, IF STOPPED: \_\_\_\_\_\_\_\_\_ NEVER SMOKED: \_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  |  |
|  |  |
|  |  | **CAFFEINE**:  (SERVINGS PER DAY)  COFFEE: \_\_\_\_\_\_\_\_\_\_ SODA: \_\_\_\_\_\_\_\_\_\_ TEA: \_\_\_\_\_\_\_\_\_\_ |
|  |  |
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|  |  |
|  |  | **ALCOHOL**:  TYPE: \_\_\_\_\_\_\_\_\_\_ AMOUNT PER DAY: \_\_\_\_\_\_\_\_\_\_ AMOUNT PER WEEK: \_\_\_\_\_\_\_\_\_\_ AMOUNT PER MONTH: \_\_\_\_\_\_\_\_\_\_ |
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| **RECENT LABS, TESTS, HOSPITALIZATIONS, MD VISITS** | **DATE/LOCATION** | **REASON** |
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**MEDICAL HISTORY**

ULCERS – STOMACH/DUODENAL YES \_\_\_\_ NO \_\_\_\_  
ACID REFLUX/GERD YES \_\_\_\_ NO \_\_\_\_  
ESOPHAGEAL STRICTURE YES \_\_\_\_ NO \_\_\_\_  
LIVER DISEASE YES \_\_\_\_ NO \_\_\_\_  
ELEVATED LIVER FUNCTION TESTS YES \_\_\_\_ NO \_\_\_\_  
PANCREATITIS YES \_\_\_\_ NO \_\_\_\_  
ALCOHOLISM YES \_\_\_\_ NO \_\_\_\_  
COLON POLYPS YES \_\_\_\_ NO \_\_\_\_  
ANEMIA YES \_\_\_\_ NO \_\_\_\_  
ANGINA YES \_\_\_\_ NO \_\_\_\_  
HEART RHYTHM DISTURBANCE YES \_\_\_\_ NO \_\_\_\_  
HEART PALPITATIONS YES \_\_\_\_ NO \_\_\_\_  
HYPERTENSION YES \_\_\_\_ NO \_\_\_\_  
HYPERLIPIDEMIA YES \_\_\_\_ NO \_\_\_\_  
HEART ATTACK YES \_\_\_\_ NO \_\_\_\_  
CONGENITAL HEART DISEASE YES \_\_\_\_ NO \_\_\_\_  
CONGESTIVE HEART FAILURE YES \_\_\_\_ NO \_\_\_\_  
PACEMAKER/DEFIBRILLATOR YES \_\_\_\_ NO \_\_\_\_  
HEART VALVE REPLACEMENT YES \_\_\_\_ NO \_\_\_\_  
STROKE/TIA’S YES \_\_\_\_ NO \_\_\_\_  
SEIZURES YES \_\_\_\_ NO \_\_\_\_  
DIZZINESS/FAINTING YES \_\_\_\_ NO \_\_\_\_  
ASTHMA YES \_\_\_\_ NO \_\_\_\_  
SLEEP APNEA YES \_\_\_\_ NO \_\_\_\_  
COPD YES \_\_\_\_ NO \_\_\_\_  
DIABETES, TYPE I/II YES \_\_\_\_ NO \_\_\_\_  
KIDNEY DISEASE YES \_\_\_\_ NO \_\_\_\_  
GENITOURINARY DISEASE YES \_\_\_\_ NO \_\_\_\_  
THYROID/ENDOCRINE DISEASE YES \_\_\_\_ NO \_\_\_\_  
PSORIASIS YES \_\_\_\_ NO \_\_\_\_  
AUTOIMMINUE DISEASE YES \_\_\_\_ NO \_\_\_\_  
ARTHRITIS YES \_\_\_\_ NO \_\_\_\_  
GOUT YES \_\_\_\_ NO \_\_\_\_  
MENSTRUAL PROBLEMS YES \_\_\_\_ NO \_\_\_\_  
GYNOLOGICAL PROBLEMS YES \_\_\_\_ NO \_\_\_\_  
CANCER: \_\_\_\_\_\_\_\_\_\_ YES \_\_\_\_ NO \_\_\_\_  
OTHER: \_\_\_\_\_\_\_\_\_\_\_ YES \_\_\_\_ NO \_\_\_\_  
**Pharmacy Information**

Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address or Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYMPTOMS**

ARE YOU PREGANT? **(IF APPLICABLE)** YES \_\_\_\_ NO \_\_\_\_  
DO YOU HAVE A FEVER? YES \_\_\_\_ NO \_\_\_\_  
EXCESSIVE FATIGUE? YES \_\_\_\_ NO \_\_\_\_  
UNINTENTIONAL WEIGHT LOSS? YES \_\_\_\_ NO \_\_\_\_  
LOSS OF APPETITE? YES \_\_\_\_ NO \_\_\_\_  
DEPRESSION? YES \_\_\_\_ NO \_\_\_\_  
ANXIETY? YES \_\_\_\_ NO \_\_\_\_  
TENDER LYMPH NODES? YES \_\_\_\_ NO \_\_\_\_  
SWOLLEN LYMPH NODES? YES \_\_\_\_ NO \_\_\_\_  
RECENT/RECURRENT INFECTION? YES \_\_\_\_ NO \_\_\_\_  
RASH? YES \_\_\_\_ NO \_\_\_\_  
SHORTNESS OF BREATH? YES \_\_\_\_ NO \_\_\_\_  
CHEST PAIN? YES \_\_\_\_ NO \_\_\_\_  
PRODUCTIVE COUGH? YES \_\_\_\_ NO \_\_\_\_  
SEASONAL ALLERGIES? YES \_\_\_\_ NO \_\_\_\_

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| --- | --- | --- |
| **MEDICATION** | **DOSE** | **FREQUENCY** |
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| **DRUG/FOOD ALLERGIES** | **REACTION** | |
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| **LATEX ALLERGY?** | YES / NO | |