BAPTIST HOSPITAL, INC. – CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

1. Medical and Surgical Consent.

   a. I recognize that I have a condition requiring medical care and I hereby consent to such medical care and treatment and such diagnostic tests at Baptist Hospital, Inc. (the "Hospital") as the physicians and staff at the Hospital may deem necessary or advisable. I hereby consent to photographs, videos, digital images that may be recorded to document my care or used for internal education, performance improvement or scientific purposes. I consent to any x-ray examination, laboratory procedures, urine drug screen, blood drug screen, anesthesia, medical, surgical or dental treatment or Hospital services rendered to me under the general and special instructions of the physician/dentist. My consent, as signified by my signature below, shall apply to my child if born during my admission or treatment at Hospital.

   b. I understand that if I am pregnant, my physician may determine that it is necessary to take urine or blood samples to perform drug screens, and I consent to both the taking of the samples and the performance of the screens.

   c. I understand and acknowledge that this facility participates in the education of health care personnel and that students may be involved in the care I receive.

   d. I understand that an explanation of the risks, benefits and alternatives of any medical or surgical procedure performed by my physician will be explained to me by my physician except in an emergency situation.

   e. I UNDERSTAND AND AGREE THAT, AS A PATIENT, MY ATTENDING PHYSICIAN IS DIRECTING MY CARE, AND I RECOGNIZE THAT NONE OF THE PHYSICIANS PROVIDING CARE TO ME INCLUDING, BUT NOT LIMITED TO, EMERGENCY ROOM PHYSICIANS, HOSPITALISTS, SURGEONS, RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS, ARE EMPLOYED BY THE HOSPITAL. PHYSICIANS HAVE PERMISSION TO USE THE HOSPITAL FACILITIES AND MAY TAKE EMERGENCY CALLS FOR THE HOSPITAL BUT ARE INDEPENDENT CONTRACTORS AND NOT AGENTS OR EMPLOYEES OF THE HOSPITAL EVEN THOUGH THEY MAY WEAR GARMENTS OR IDENTIFICATION THAT INCLUDE THE HOSPITAL'S NAME OR LOGO. **I EXPRESSLY AGREE TO RELEASE AND DISCHARGE THE DUTY OF THE HOSPITAL AS TO SERVICES THAT MAY BE PERFORMED BY PHYSICIANS WHO ARE INDEPENDENT CONTRACTORS, BUT NOT EMPLOYEES, OF THE HOSPITAL. I UNDERSTAND THAT BY RELEASING AND DISCHARGING THE HOSPITAL OF ITS DUTY AS TO THESE SERVICES, I AM GIVING UP THE RIGHT TO HOLD THE HOSPITAL LIABLE FOR THE POTENTIAL NEGLIGENCE OF THE PHYSICIANS.**

2. Release of Information. I authorize the Hospital to disclose all or any part of my record, including my medical records, to any person or entity that may be liable to the Hospital or me for all or part of the Hospital's charges, including, but not limited to: a) hospital or medical service companies; b) insurance companies; c) workers' compensation carriers; d) welfare or social services agencies; e) my employer; f) any entity that provides pharmaceutical products or services to the Hospital for my benefit and that offers reimbursement to the Hospital for the provision of those products and services. All such disclosures will be conducted in accordance with applicable laws. I further agree to release the Hospital, its employees, agents and assigns, and representatives from any and all liability arising out of the release of my records pursuant to this paragraph.

3. Consent for Testing and Sharing of Test Results. If, in the course of my medical care, a health care worker is exposed to my blood or other bodily fluids I give consent for a sample of my blood to be tested for HIV or Hepatitis B antibodies. I understand and acknowledge that the health care worker will be notified of the results for purposes of his or her treatment. I will also be notified of the results.

4. Personal Valuables. I understand the Hospital is not responsible for the safekeeping of my personal belongings such as money, jewelry, dentures, hearing aids, eyeglasses, watches, credit cards, or phones.

5. Assignment of Insurance Benefits. I assign payment of all applicable insurance payments directly to the Hospital and agree that the Hospital may receive any such payment, and I further understand and agree that I will be responsible for charges not covered by this assignment. I assign any state disability benefits to which I may be entitled. I appoint the Hospital as my legal representative under Florida Statutes sec. 316.066 for the sole purpose of obtaining police or crash reports and other data related to the accident or incident for which I sought treatment at the Hospital.

Patient Identification

6. Medicare-Medicaid Patients Certification. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all records, including but not limited to medical records, required to act on this request and that payment of authorized benefits be made directly to the Hospital and the physician involved in my care for any services furnished me by the Hospital and said physicians.

7. Indigent Drug Program. If I qualify for assistance, I agree to comply with the policies of the Hospital's drug program for indigents, which may provide me with replacement of certain medications and/or copay assistance. I consent to participate in this program and authorize the Hospital to sign all forms and applications pertaining to patient assistance and co-pay programs on my behalf.

8. Patient Information Packet. I acknowledge that I have been offered Hospital's Patient Admission Packet, which includes the notice of patients' rights and the Notice of Privacy Practices.

9. Emergency Care. I understand that if I come to the Hospital's dedicated emergency department seeking care, I will be screened for an emergency medical condition and, if I have an emergency medical condition, the Hospital will provide stabilizing treatment, admit me to the Hospital as an inpatient, or transfer me if medically needed. The screening and the stabilization will be provided **regardless of my ability to pay.** I certify that the Hospital has not withheld, delayed, or conditioned screening or stabilizing care based upon my signing or refusing to sign this paragraph or based upon any payment related concerns.

10. Obligation to Pay My Hospital Bill. I acknowledge that I am financially responsible for my Hospital bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance, and I agree to pay them promptly. If my insurance does not pay my claim after reasonable attempts by the Hospital, I may be responsible for paying my entire bill to the Hospital.

11. Financial Assistance. **I understand the Hospital has financial assistance programs available to those individuals who are unable to pay for their care, based upon a determination of financial need.** By signing below, I acknowledge that the Hospital's financial assistance policy is available to me on the Hospital's webpage or, will be made available to me upon request from the person who provided me this form. I understand I may be asked to provide my personal financial information and/or submit to a credit check in order to qualify for the financial assistance program. If I do not qualify for a financial assistance program, I understand that I may be able to enter into a payment plan with the Hospital.

12. Payment Contact. I authorize the Hospital, its service providers (including service providers contacting me about obtaining potential financial assistance for my account(s) and/ or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using prerecorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

13. Video Surveillance. I consent to video surveillance monitoring throughout the Hospital's facilities for safety purposes, which may include my private hospital room with appropriate notice.

14. Children born during Admission or Treatment. My consent to all of the elements set forth above, shall also apply to any child of mine who is born during admission or treatment at Hospital.

_____

Patient or Patient's Representative (if patient is minor or unable to sign) Date of Birth Relationship to Patient Date and Time

If patient is a minor, the parent must also complete the following:
The undersigned guarantees and agrees to pay to the Hospital on demand for any and all indebtedness of the patient to the Hospital relating to services provided pursuant to this consent form.

Guarantor Date and Time

_____
Guarantor (Print Name)

Patient Identification

Baptist Medical Group
Patient Consent and Responsibility Agreement

Welcome to Baptist Medical Group (BMG). We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.

CONSENT FOR TREATMENT. I consent to all services as ordered or performed by my BMG physician, advanced practice provider, or their assistants and designees. This care may include, but is not limited to, medical examination and treatment, administration of drugs or vaccines, nursing care, laboratory, and x-ray procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me about the results of any treatment.

OBLIGATION TO PAY MY BMG BILL: I understand that all charges for services rendered are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my provider bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by a third party payor, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I authorize BMG to bill my health plan or other applicable insurer or third party payor and I assign to BMG all of my rights and claims for reimbursement by a third party payor. I authorize BMG to release to all third party payors any medical information that is required in order for BMG to receive payment for its services to me. I will inform my provider of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire provider bill if my third party payor refuses to pay after reasonable attempts to collect from the third party payor.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be rescheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance may result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my third party payor requires pre-authorizations for tests or for referrals to specialists. I understand the BMG office staff may assist me with scheduling referrals or diagnostic testing, but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

FINANCIAL ASSISTANCE: I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with Baptist Health Care's Financial Assistance Policy. I understand it is my responsibility to contact a Patient Account Specialist at BMG's business office at (850) 469-2000 to request financial assistance or access the policy and application at https://ebaptisthealthcare.org/PatientFinancialResources. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have insurance third party payor, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, I may be eligible for a discount when full payment is made at time of service.

CNT

Patient Identification

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write, and will pay these fees upon notice.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact the practice or my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There may also be a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

PATIENT PORTAL: I understand this practice may have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the patient portal which may be accessed at https://ebaptisthealthcare.org/PatientPortal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to my provider to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from the practice and its authorized agents.

NOTICE OF PRIVACY PRACTICES: I understand that Baptist Health Care's Notice of Privacy Practices provides information about how my health information may be used and disclosed. I have been offered and (if requested by me) received a copy of the Notice of Privacy Practices.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND CONSENT TO TREATMENT BY BMG AND I AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Personal Representative Signature	**Date**
Print Patient/Personal Representative Name	**Personal Representative's relationship to patient:**

Patient Identification

Welcome to Baptist Medical Group Primary Care – North Hill!

Please read the below information carefully to prepare for your upcoming appointment:

- Please arrive 15 minutes prior to your scheduled appointment with completed paperwork. If you paperwork is not completed, please arrive 30 minutes early. Late arrivals could end in the need to reschedule.

- Please bring a list of all your medications, photo identification, and insurance card(s).

- Please be prepared to pay your copay or coinsurance payment at the time of service.

- In general, our physicians do not prescribe narcotic pain medications, sedatives such as Xanax or Klono pin, or prescription sleeping pills such as Ambien or Restoril for chronic or long term use.

- If you require these medications and are already seeing pain management or psychiatry for the management of these conditions, our doctors will be happy to see you to provide primary care.

- If you are looking for a doctor to manage your primary care and prescribe narcotics, sedatives, or sleeping pills, our doctors will not be able to provide these services.

- All new patient appointments must be confirmed within 24 hours of your scheduled date/time. Unfortunately, if the office is unable to confirm your appointment, it will be cancelled.

Patient Registration Form

Last Name _____ First Name _____ MI ___

Social Security ___ - ___ - ____

Gender ☐ Male ☐ Female
- ☐ Additional gender category or other
- ☐ Choose not to disclose
- ☐ Female-to-Male (FTM)/Transgender
- ☐ Genderqueer, neither excl male or female
- ☐ Male-to-Female (MTF)/Transgender

Marital Status
- ☐ Divorced
- ☐ Legally Sep
- ☐ Life Partner
- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Unknown

Date of Birth ___/___/_____

Address _____ City _____ State _____ Zip _____

Email _____

Primary Phone (____) _____ - _____ Secondary Phone (____) _____ - _____

Preferred Language _____

Race
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Unknown/Decline to Answer

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown/Decline to Answer

Responsible Party: This section refers to the person/party who should receive the bill

Relationship to Patient ☐ Self (skip this section) ☐ Parent ☐ Spouse ☐ Other _____

Last Name _____ First Name _____ MI ___

Social Security ___ - ___ - ____ Date of Birth ___/___/_____ Sex ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Primary Phone (____) _____ - _____ Secondary Phone (____) _____ - _____

New PT Paperwork

Medications and Allergies

Name _____ Date of Birth ___/___/_____

Pharmacy Name _____ Mail Order _____

Allergies

Please list any allergies to medications or foods. Example of reactions: rash or hives, trouble breathing, nausea, etc.

Name	Reaction		Name	Reaction
1.			7.	
2.			8.	
3.			9.	
4.			10.	
5.			11.	
6.			12.	

Medications

If you bring your medication bottles to your appointment, please skip this section.

Name	Dose	Frequency

Medical History Form

Name _____ Date of Birth ___/___/_____

Chief Complaint (current symptoms)
1. _____
2. _____
3. _____

Immunizations and Wellness: Please list month and year of last

Vaccines: Tetanus ___/____ Flu ___/____ Pneumonia ___/____ Shingles ___/____

Diabetics: Dilated Eye Exam ____/____ Foot Exam ____/____

Over 50: Colonoscopy ___/____ Bone Density Test ___/____

Female: Mammogram __/____ Pap Smear __/____ Abnormal? ☐ Yes ☐ No

Contraception Type
- ☐ Vasectomy
- ☐ IUD Year ____
- ☐ Pill
- ☐ Tubal
- ☐ Condoms
- ☐ Depo
- ☐ Other _____

Last Menstrual Period ___/___/_____

Pregnancies _____
Miscarriages _____
Abortions _____
Deliveries _____

Hysterectomy?
- ☐ Yes
- ☐ No

Reason? _____

Male: PSA ___/____

Past Medical History: Please check all that apply

	Yes		Yes		Yes
Allergies	☐	Diabetes	☐	Seizure Disorder	☐
Anemia	☐	Heart Arrhythmia/Palpitations	☐	Sexually Transmitted Infection	☐
Anxiety Disorder	☐	Heart Attack or Bypass Surgery	☐	Stomach Ulcer	☐
Arthritis	☐	Heart Disease	☐	Stroke	☐
Asthma	☐	High Blood Pressure	☐	Thyroid disorder	☐
Birth Defects	☐	High Cholesterol	☐	Other: _____	☐
Blood Clots	☐	Kidney Disease	☐	_____	
Blood Transfusion	☐	Liver Disease	☐	_____	
Bone Fracture	☐	Osteoporosis	☐	_____	
Cancer: Type	☐	Reflux	☐	_____	
Depression	☐	Respiratory Disease (e.g. COPD)	☐	_____	

Surgical History: Please list any surgeries you have had and the month and year

1. _____ Date ___/____
2. _____ Date ___/____
3. _____ Date ___/____
4. _____ Date ___/____
5. _____ Date ___/____
6. _____ Date ___/____

Name _____ Date of Birth ___/___/_____

Family History					
	Who		Who		Who
Blood Clots	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal	Diabetes	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal	Prostate Cancer	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal
Breast Cancer	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal	Heart Disease	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal	Stroke	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal
Colon Cancer	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal	Osteoporosis or Hip Fracture	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal	Other	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal
Depression	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal	Ovarian Cancer	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Maternal ☐ Paternal	☐ Other _____	

Father	Age (if living) _____	Age at death (if deceased) _____
Mother	Age (if living) _____	Age at death (if deceased) _____
Sibling	Age (if living) _____	Age at death (if deceased) _____
Sibling	Age (if living) _____	Age at death (if deceased) _____
Sibling	Age (if living) _____	Age at death (if deceased) _____

Social History					
Tobacco Use	☐ Never	Current	Packs per day _____	Year began _____	Type ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigars ☐ E-Cigarettes
		Former	Packs per day _____	Year began _____	
Alcohol Use	☐ Never	Current	Drinks per day ____ per month ____ per year ____ Year began _____		Type ☐ Beer ☐ Wine ☐ Liquor ☐ Other _____
		Former	Drinks per day ____ per month ____ per year ____ Year began _____		Type ☐ Beer ☐ Wine ☐ Liquor ☐ Other _____
Caffeine	☐ Never	☐ Yes	Amount per day _____		Type _____
Exercise	☐ Never	☐ Yes	Sessions per week _____		Type _____

Review of Systems

Name _____ Date of Birth ___/___/_____

Please check Yes or No if you are currently experiencing any of the symptoms below:

Y	N	General	Y	N	Skin	Y	N	Breast
☐	☐	Decreased Appetite	☐	☐	Dry Skin	☐	☐	Breast Lump
☐	☐	Chills	☐	☐	Itching	☐	☐	Nipple Discharge
☐	☐	Fever	☐	☐	Redness	☐	☐	Nipple Retraction
☐	☐	Malaise/Fatigue	☐	☐	Rash	☐	☐	Tenderness
☐	☐	Weight Loss	☐	☐	Skin Color Changes	☐	☐	Swollen Glands
☐	☐	Weight Gain	☐	☐	Mole Changes	☐	☐	Swelling
			☐	☐	Open Sores/Wounds	☐	☐	Nipple Pain
						☐	☐	Recent Breast Size Changes

Y	N	Eye	Y	N	Ear	Y	N	Nose
☐	☐	Itching	☐	☐	Discharge	☐	☐	Congestion
☐	☐	Tearing/watering	☐	☐	Hearing Loss	☐	☐	Nose Bleeds
☐	☐	Pain	☐	☐	Pain	☐	☐	Sneezing
☐	☐	Sensitivity to Light	☐	☐	Ringing in Ears	☐	☐	Decreased Sense of Smell
☐	☐	Vision Changes	☐	☐	Pulling on Ear	☐	☐	Runny Nose
☐	☐	Discharge				☐	☐	Sinus Pain
☐	☐	Redness				☐	☐	Sinus Pressure
☐	☐	Dryness				☐	☐	Post Nasal Drip

Y	N	Mouth and Throat	Y	N	Respiratory	Y	N	Cardiovascular
☐	☐	Pain	☐	☐	Shortness of Breath	☐	☐	Chest Pain
☐	☐	Sore Throat	☐	☐	Shortness of Breath on Exertion	☐	☐	Claudication/Extremety Pain
☐	☐	Hoarseness	☐	☐	Shortness of Breath at Rest	☐	☐	Lower Extremity Swelling
☐	☐	Dryness	☐	☐	Cough	☐	☐	Orthopnea or Difficulty Breathing While Lying Down
☐	☐	Difficulty Swallowing	☐	☐	Sputum Production	☐	☐	Palpitation or Fast Heart Beat
☐	☐	Difficulty Chewing	☐	☐	Coughing Up Blood	☐	☐	Syncope or Fainting/Passing Out
☐	☐	Dental Problems	☐	☐	Wheezing	☐	☐	Lightheadedness/Dizziness
			☐	☐	Snoring	☐	☐	Diaphoresis or Excessive or Abnormal Sweating

Y	N	Gastrointestinal	Y	N	Genitourinary	Y	N	Neurological
☐	☐	Abdominal Pain	☐	☐	Dysuria - painful urination	☐	☐	Confusion
☐	☐	Rectal Pain	☐	☐	Urinary Frequency	☐	☐	Memory Loss
☐	☐	Diarrhea	☐	☐	Urinary Urgency	☐	☐	Dizziness
☐	☐	Nausea	☐	☐	Urinary Hesitancy	☐	☐	Headache
☐	☐	Vomiting	☐	☐	Change in Bladder Habits	☐	☐	Numbness
☐	☐	Black Tarry Stools	☐	☐	Urinary Incontinence or Urine Leakage	☐	☐	Generalized Weakness
☐	☐	Mucous in Stool	☐	☐	Sexual Dysfunction	☐	☐	Difficulty Speaking
☐	☐	Change in Bowel Habits	☐	☐	Penile Discharge	☐	☐	Difficulty with Ambulation
☐	☐	Stool Incontinence	☐	☐	Pain	☐	☐	Tingling
			☐	☐	Change in Menses	☐	☐	Loss of Balance
			☐	☐	Dyspareunia or Painful Intercourse	☐	☐	Unusual Sensation
			☐	☐	Vaginal Discharge	☐	☐	Radicular Symptoms
			☐	☐	Vaginal Pruritus or Itching	☐	☐	Rotational Symptoms
			☐	☐	Vulvar Swelling			

Y	N	Psychological	Y	N	Musculoskeletal	Y	N	Heme/Lymph
☐	☐	Anxiety	☐	☐	Arthralgia or Joint Pain	☐	☐	Bruising Easily
☐	☐	Depression	☐	☐	Joint Swelling	☐	☐	Enlarged or Tender Lymph Nodes
☐	☐	Hallucinations	☐	☐	Joint Redness	☐	☐	Night Sweats
☐	☐	Insomnia	☐	☐	Joint Stiffness	☐	☐	Abnormal Bleeding
☐	☐	Mood Problems	☐	☐	Neck Pain			
☐	☐	Fearful	☐	☐	Back Pain			
☐	☐	Suicidal Ideation Or Thoughts of Self Harm	☐	☐	Myalgia or Muscle Pain			
☐	☐	Homicidal Ideation Or Thoughts of Harming Others	☐	☐	Muscle Weakness			
☐	☐	Delusions						
☐	☐	Stress						

Y	N	Endocrine	Y	N	Allergic/Immunologic	Y	N	Other
☐	☐	Unusual Change in Weight	☐	☐	Environmental Allergies	☐	☐	
☐	☐	Cold or Heat Intolerance	☐	☐	Food Allergies	☐	☐	
☐	☐	Hot Flashes	☐	☐	Hay Fever	☐	☐	
☐	☐	Polydipsia or Extreme Thirst	☐	☐	HIV	☐	☐	
☐	☐	Polyuria or Excessive Urination	☐	☐	Latex Allergy	☐	☐	
☐	☐	Changes in Appetite	☐	☐	Immunologic Disorder	☐	☐	
			☐	☐	Immunosuppressive Disorder	☐	☐	