NORTHSIDE HOSPITAL

Northside Heart

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

The Northside Hospital Physician Office Practice identified above is hereby authorized to **(Please mark appropriate box):**
☐ **Release to OR** ☐ **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) **(Please identify by name or general description and provide address, if known):**_____

_____

_____

The following protected health information regarding the patient **(Please mark appropriate box(es))**: ☐ Complete Medical Record
☐ Abstract of Medical Record (physician dictated reports & diagnostic reports) ☐ Labs only ☐ Radiology only ☐EKG only

☐ Other **(Please specify clearly)**_____

For the following dates of service: _____

Unless you state otherwise, this authorization **includes** the release and disclosure of **all medical records and information**, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse, including drugs and alcohol**, except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a different consent form is required.

Unless you state otherwise by marking one or both boxes below, this authorization **includes** the release and disclosure of records and information which may include (i) **HIV/AIDS** confidential information and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider, and **you affirmatively waive any protections from disclosure** that might otherwise apply. **HIV/AIDS confidential information** is defined by Georgia law to include the fact that a patient has had an HIV test or been counseled about HIV, even if the test is negative. **NOTE:** Unless otherwise permitted by law, the release of **HIV/AIDS** confidential information and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I **object** to the release of **HIV/AIDS** confidential information.
☐ I **object** to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is **(Please describe each purpose of the requested use or disclosure):**_____

_____

This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates:
(a)_____ **(in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit)**; (b) the date I revoke this authorization in writing; or (c) three (3) years from the date on which I signed this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries or becomes emancipated under Georgia law.

Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.

_____
Witness

_____ AM/PM _____
Date Time

_____
Interpreter (if applicable)
Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

_____
Signature of Patient or Legally Authorized Representative, Including Legal Guardian, Health Care Agent, or Parent of Minor Child

Print name: _____

Relationship to patient: _____

Reason patient unable to sign: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

White - Medical Records
Yellow - Patient

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

This authorization can be revoked by submitting a written request to the Office Manager at the Northside Hospital Physician Office Practice identified on the front of this form. I understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage. I also understand that treatment of the patient (either myself or the patient named above) at the Northside Hospital Physician Office Practice and/or Northside Hospital will not be affected if I refuse to sign this authorization.

Note: To authorize the disclosure of psychotherapy notes, the additional form entitled ***Authorization for Release of Psychotherapy Notes*** will need to be completed. To authorize the disclosure of patient records from the Northside Hospital Behavioral Health Recovery Program, the additional form entitled ***Authorization for Release of Alcohol and Drug Abuse Patient Records*** will need to be completed.

I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided (including, but not limited to, electronic transmission, paper copies, CDs, films, and flash drives) may be subject to re-disclosure by the recipient and may no longer be subject to protections under the federal privacy laws and regulations. I hereby release the Northside Hospital Physician Office Practice, Northside Hospital, Inc., and their agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of the medical records and information I have authorized above.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize re-disclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse which is protected by Federal confidentiality rules (42 C.F.R. Part 2), the following notice shall also apply.

> **This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

NORTHSIDE HOSPITAL

Northside Heart

Patient Name _____

Date of birth _____ /_____ /_____
Month Day Year

English - Spanish

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: Unless I have specified otherwise, verbally or in writing, in consideration of the services provided at Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. If admission is for pregnancy, assignment of benefits will also apply to any newborn child.

PRECERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Northside Hospital is willing to admit as requested by my physician. **I also understand** that I may be financially responsible for all hospital charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Hospital and Provider-Based Services — In addition to a bill received from Northside Hospital, you may receive a bill for the professional component of treatment. Although Northside Hospital may be a provider in an insurance network, the physician or professional service group may or may not be a covered provider of service. Medicare and Medicare Advantage patients will receive a coinsurance liability estimate. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

Physician Practice Locations — If services are received in a physician practice, which is not a provider-based outpatient location of Northside Hospital, insurance benefits will be processed as a physician office visit.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent a year. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay, unsatisfied deductible, and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

_____ I authorize Northside Hospital, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at Northside Hospital or payment for the services I received at Northside Hospital, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Northside Hospital.

_____ I do not agree with the above statement and do not wish to be contacted by the use of any automatic dialing system; by pre-recorded forms of voice/messaging systems; by electronic mail or by receiving voice messages on my cell phone, except for clinical issues

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice provides information about how Northside Hospital and the Northside Hospital medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full.

I understand that Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices. Although the Hospital and Medical Staff members have established an organized health care arrangement for purposes of complying with privacy laws, some or all of the health care professionals performing services in this hospital or its outpatient centers are not employees or agents of the Hospital and remain independent contractors. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that the Notice is subject to change. If Northside Hospital changes the Notice, I may obtain a copy of the revised Notice at Northside's website (www.northside.com).

_____ _____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

Reorder #26703 PP0004 (NHRT)
Piedmont Graphics 02/19/16

ANNUAL ACKNOWLEDGEMENT

NORTHSIDE HOSPITAL

Northside Heart

Full Name:_____ Date of Birth _____
(First) (Middle) (Last)

Gender (circle) Male Female **Marital Status (circle)** Single Married Divorced Widowed

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____

*Email_____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Other ☐ Unknown/Declined

Preferred Language ☐ English ☐ Spanish ☐ Chinese(Cantonese) ☐ Chinese(Mandarin) ☐ French ☐ German
☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other

Employer _____ Employer Phone_____

Preferred Communication for Appointment Reminders: ☐ Phone Call ☐ Automated Text ☐ Automated Email

If this practice lacks the capability for text or email reminders, may we use the phone number for reminders ☐ yes ☐ no.

Pharmacy Information

Pharmacy Name _____ Phone_____ Fax_____

Pharmacy Address _____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name _____ Date of Birth _____Relationship to Patient_____

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____ *Email _____

***Note:** *By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal if available at the practice. To ensure the security of your information, it is against our policy to email patient information. You may complete the Request for Confidential Communications form to request limitations on the method or content of communication.*

Emergency Contacts Information and Relationship to Patient:

Name _____Relationship _____Phone_____

Name _____Relationship _____Phone_____

Referring Physician Information:

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Primary Care Physician Information (if different than referring physician):

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Does your insurance require a referral? ____YES ____NO; **if yes,** please provide the referral to the receptionist

	Primary Insurance	**Secondary Insurance**
Name of Insurance		
Name of Policy Holder		
Date of Birth of Policy Holder		
Policy/Member ID Number		
Group/Plan Number		
Phone Number		
Effective Date of Policy		

Patient/Guarantor Signature _____ **Date** _____

Reorder #25796 PP0001 (NHRT)
Piedmont Graphics 02/19/16

PATIENT REGISTRATION FORM

NORTHSIDE HOSPITAL

Northside Heart

English - Spanish

PATIENT'S NAME: _____ DATE OF BIRTH:_____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at a Northside Hospital affiliated medical practice ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals. The Minor Procedures are performed by a physician or qualified mid-level provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to the Practice or any lab used by the Practice retaining any tissue specimens, medical devices, foreign objects, or fetal remains removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Consent To Download Prescription Records. The Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. 3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

Medications From Outside Source. I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice; The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and If a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS.

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

_____ _____

Witness Date Time | Signature of Patient or Legal representative Date Time

_____ _____

Interpreter (Note: if phone interpretation used, record interpreter ID#) | Relationship to patient reason patient can't sign

Reorder #26702 PP0042 (NHRT)
Piedmont Graphics 02/20/16

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

NORTHSIDE HOSPITAL

Northside Heart

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____ Date:_____

As a patient, you may designate a spouse, family members, friends, or other persons with whom Northside can communicate about your health care status. This form is not required in all circumstances for your doctor or others at Northside to be able to communicate with your family about your health care. However, by designating certain individuals who you want to be informed about your care on this form, you can ensure that your provider can communicate without delay with those people you have designated below.

I, _____, consent to have my health information and care discussed with the following people:

First and Last Name	Relationship:

I understand that this Consent can be revoked by submitting a written request to the Practice Coordinator at the Northside Hospital Physician Office Practice identified at the top of this form. I understand that I have the right to revoke this Consent in writing at any time except to the extent that action has already been taken in reliance on it. This Consent shall remain in effect until the date I revoke it in writing.

_____ _____

Signature of Patient or Legal representative Print name:

_____ AM/PM _____ _____

Date Time Relationship to patient:

_____ _____

Interpreter (if applicable) Reason patient unable to sign:

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

Please complete this form and return it to the Practice.

FOR INTERNAL PURPOSES ONLY:

Date Consent Received:_____

NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS

NORTHSIDE HEART

Date of birth _____ /_____ /_____
Month Day Year

"Office Use Only"
Data Entered by: _____

Patient Name: _____ **Date:** _____

Age: _____ Sex: M F

Chief Complaint: _____

Who is your Primary Care Physician? _____ Phone# _____

CARDIAC HISTORY

Do you have chest pain? Yes

If so, when did it begin? _____

What is its frequency? _____

What is the duration of pain?	(seconds)	(minutes)	(hours)	(days)		
The pain worse with:	(stress)	(exercise)	(meals)	(sleep)	(position)	(other)
The pain is better with:	(rest)	(aspirin)	(nitroglycerin)	(other)		
What does the discomfort feel like?	(sharp)	(aching)	(burning)	(tightness)	(pressure)	

Have you had any of the following cardiac studies? Please fill in date of study if applicable.

Exercise Treadmill	Echo	Nuclear Scan	Catherization
Date _____	Date _____	Date _____	Date _____

Please circle yes if this applies to you:

Do you get any skipped heartbeats or racing heart?	Yes	No
Do you have shortness of breath while lying flat?	Yes	No
Do you wake up with shortness of breath?	Yes	No
Do you get swelling of the ankles?	Yes	No
Do you get calf pain while walking?	Yes	No
Have you ever fainted?	Yes	No

Please list the name, dosage and frequency of current medications:

MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT INTAKE FORM

Patient Name: _____ **Date:** _____

ALLERGIC/IMMUNOLOGIC

Do you have any drug allergies? Yes No

History of skin reaction or other adverse reactions to:

Antibiotics: Name _____

Pain medication: Name _____

Anesthetics: Name _____

Blood thinners: Name _____

Contrast agents, iodine, dyes or shellfish: Name _____

Other drugs or medication: Name _____

Known food allergies Name _____

FAMILY HISTORY

Does anyone in your family have a history of:

☐ Heart disease Relationship _____

☐ Heart surgery Relationship _____

☐ Hypertension Relationship _____

☐ Diabetes Mellitus Relationship _____

☐ Stroke Relationship _____

☐ Vascular problems Relationship _____

Age of mother _____ Age of father _____ Number of siblings _____

If parents or siblings are not living, please list age and cause of death:

Father- age _____ Cause _____

Mother- age _____ Cause _____

Sibling- age _____ Cause _____

CARDIAC RISK FACTORS

Please circle yes if this applies to you:

History of stroke/peripheral circulation problems? Yes No

Do you have a history of high blood pressure? Yes No number of years _____

Do you have a history of diabetes mellitus? Yes No number of years _____

Have you ever been told that you have elevated cholesterol? Yes No number of years _____

If so, what is your level? Total cholesterol _____ "Bad" cholesterol _____

Do you smoke? Yes No number of years _____ cigs per day _____

If no, have you ever smoked before? Yes No year quit _____

Do you exercise regularly at least 30 minutes 3 times per week? Yes No

Please circle appropriate exercise activity: (Walk) (Run) (Aerobics) (Sports)

Patient Name: _____ **Date:** _____

PAST HISTORY

Please list any surgical procedures, major illnesses, hospitalizations and their dates:

NAME	DATE
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Where were you born? _____ If outside the US, what year did you come to the states? _____

How would you describe your ethnic background? _____

Are you: ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced ☐ Life partner

Do you have any children? Yes No If yes, how many? _____ What are their ages? _____

Are you employed? Yes No If yes, what is your job title? _____

Occupation: Please state an accurate description of your work activity:

_____

_____

If retired, what did you do before? _____

What is your favorite activity? _____

Do you exercise? ☐ Yes, If 'yes indicate the frequency by checking below ☐ No:

____ Sedentary (Sitting) ____ Minimally (Once per Week) ____ Active (no formal exercise routine)

____ Moderately (1-3 times weekly) ____ Regularly (Consistently) ____ Heavily (greater than 4 times weekly)

Do you drink or indulge in any of the following substances and if so, please indicate the frequency:

Alcohol	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Caffeine	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Cocaine	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Depressants	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Illicit Drugs	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
	If 'yes', please list the type of substance: _____					
Marijuana	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Tobacco	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
	If 'yes', please list the type of substance: _____					
	How often? _____ *How much (example: cigarettes 1 pack)?* _____					

Do you have any stressful problems? (Please circle) Family Work

Describe: _____

_____

Please list any questions you have for your doctor:

1. _____
2. _____
3. _____
4. _____

PLEASE CONTINUE TO NEXT PAGE

Patient Name: _____ **Date:** _____

REVIEW OF SYSTEMS

Please circle all that apply

Constitutional
Fatigue
Fever
Weight Gain
Weight Loss
Chills
General Good Health

HENT
Headaches
Nose Bleeding
Problems Swallowing

Cardiovascular
Chest Pain
Shortness of Breath w/Exercise
Heart Racing/Skipping
Irregular Heart Beats
Dizziness
Dizziness when Standing Up
Lightheadness
Fainting
Swelling
Leg Pain with Walking
Waking at Night w/Difficulty Breathing
Palpitations

Respiratory
Shortness of Breath
Wheezing
Coughing
Sleep Apnea
Sleep Problems

Gastrointestinal
Nausea
Vomiting
Diarrhea
Blood in Stool

Genitourinary
Blood in Urine
Difficulty Urinating

Integument
Rash

Neurologic
One Sided Weakness
Seizures

Musculoskeletal
Muscle Aches
Muscle Cramps

Psychiatric
Anxiety
Depression

Heme-Lymp
Easy Bleeding