NEW YORK Spine & Pain PHYSICIANS
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NEW YORK SPINE & PAIN PHYSICIANS
NEW PATIENT QUESTIONNAIRE

**Office use Provider __________
Appt time ________ Entered _____
Ht _________ Wt_____________
BP_________________________

DEMOGRAPHICS- *To be completed by all patients*

Patient Name: ____ Today's Date: ___/____/___

Patient Address: ____________________________________ City: ________ State: ____ Zip: _________

Home Phone #: (____) ____-______ ☐Preferred Work #: (____) ____-______ ☐Preferred Cell #: (____) ____-______ ☐Preferred

Date of Birth: ___/____/____ SSN: __________________________ Marital Status: ________________

Gender: ☐Male ☐Female Preferred Language: __________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Refuse to Report

Race: ☐ American Indian, Alaska Native ☐ Asian ☐ Native Hawaiian
☐African American ☐White
☐Other Pacific Islander ☐Other Race ☐ Refuse to Report

*Email Address: ____

HEALTH INSURANCE COVERAGE- *To be completed by all patients. (In the case of Workers' Compensation or No Fault, this information will only be used if coverage is denied).*

Health Insurance Company Name: ____

Address: ___________________________________ City: _______ State: _______ Zip Code: _________

Phone #: (____) ____-____

Insured's Name: ________________________________ Relationship to Patient: ___________________

Insured's Date of Birth: __/__/____ Insured's Social Security #: _________________

Insured's Employer: ________________________ Group #: ______________________

ID #: ____________________ Medicare ID #: ______________________

Do you have secondary insurance? ☐Yes ☐No Carrier Name: _______________ID#: ____________

My Visit is NOT related to an accident (*Please Initial*): _____________

NO FAULT/LIABILITY- *Please complete this section is your illness/injury is the result of an accident (auto or otherwise- but NOT related).*

Insurance Company Name: ________________________________ Date of Accident: _______________

Address: _______________________________________City: _______State: ______ Zip Code: ________

Policy #: ______________ Claim #: _________________ Claims Adjuster: ________________________

Phone #: (____) ____-____ Location of Accident (State): _____________________________________

WORKERS' COMPENSATION- *Please complete this section if your illness/injury is work related.*

Insurance Company Name: ___________________________________ Date of Accident: _____________

Address: _______________________________________City: _______State: ______ Zip Code: ________

Claim #: ________________Claims Adjuster: __________________________Phone #: (____) ____-____

WCB Case #: ________________ Employer at the time of the accident: ___________________________

Address: _________________________________City: ________ State: ________Zip Code: __________

Contact Person: ____ Phone #: (____) ____-____

Patient's usual work activities on date of illness/injury?

____

DISABILITY- *To be completed by all patients*

Are you, or have you been disabled? ☐YES ☐NO Date: ______________________

Are you out of work? ☐YES ☐NO

Are you partially or totally disabled? ____

Name of physician who placed you on disability: ____

Are you receiving disability payments? ☐YES ☐ NO If yes, for how long? __________________

Are you currently involved in a lawsuit? ☐YES ☐ NO If yes, please explain below:

____

Attorney Name: ____ Phone #: (____) ____-____

Address: ___________________________________City: ________State: ______ Zip Code: ________

EMPLOYMENT- *To be completed by all patients.*

Are You Currently Employed: ☐YES- FULL TIME ☐YES- PART-TIME ☐NO ☐RETIRED

Patient's Employer: ______________________________ Employer Phone #: (____) ____-_____

Patient's Employer's Address: ____________________________ Occupation: ___________________

PHYSICIANS- *Please list all of your providers. If you do not have a particular physician, enter N/A.*

Primary Care Provider: ____________________________________ Phone #: (____) _____-_____

Referring Provider: ____ Phone #: (____) _____-_____

Cardiologist: ____ Phone #: (____) _____-_____

Neurologist: ____ Phone #: (____) _____-_____

Pulmonologist: ____ Phone #: (____) _____-_____

Endocrinologist: ____ Phone #: (____) _____-_____

Other: ____ Phone #: (____) _____-_____

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➢ AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications, and other information that is pertinent to our patients' care. In this event, we would discuss such information with the person whom you sign authorization and designate below. Please complete the following section:

I hereby authorize New York Spine & Pain Physician to discuss any information required in the course of my examination or treatment when I cannot be reached by phone to the following designated person(s):

Name of Designee: _______________________ Phone Number: _______________________

Relationship to Patient: ____________________

Name of Designee: _______________________ Phone Number: _______________________

Relationship to Patient: ____________________

This individual will be considered your emergency contact.

☐ None

I agree to all of the above information.

____ _________________________

Patient Signature or Legal Guardian Signature Date

➢ HIPAA ACKNOWLEDGEMENT-

THE PURPOSE OF THIS DOCUMENT IS TO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE "HIPAA PRIVACY ACT" FROM THIS OFFICE. I AM AWARE THAT IF I HAVE ANY QUESTIONS REGARDING THIS I CAN CONTACT THE OFFICE MANAGER.

____________________________________ __________________________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

➢ MEDICAL INFORMATION RELEASE-

I, _________________________GIVE NEW YORK SPINE & PAIN PHYSICIANS PERMISSION TO OBTAIN MY PAST MEDICAL HISTORY FROM MY REFERRING PHYSICIAN OR PRIMARY CARE PHYSICIAN.

______________________________ __________________________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

➢ I hereby authorize payment directly to New York Spine & Pain Physicians for services rendered to me and paid by my carrier. I understand that if my insurance carrier does not make payment for these charges I am financially responsible for the charges for services rendered.

______________________________ __________________________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

NEW YORK Spine & Pain PHYSICIANS
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Our goal is to provide and maintain a positive physician-patient relationship. Providing you with our financial policy in advance allows for a good flow of communication and enables us to operate efficiently. To prevent misunderstanding between patients and our practice, New York Spine Physicians (the 'Practice') adheres to the following patient financial policy. Your complete understanding of your financial responsibilities is an essential element of the physician- patient relationship and continued medical management. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- The Practice must collect copays at the time of service and is required to report to the carrier any enrollees failing to pay the co-pay. For your convenience we accept cash, personal check, credit cards (Visa, MasterCard or Discover), and money orders. The Practice is required to collect these based on your benefit contract and the Practice's contractual agreement with your insurance carrier.

- It is your responsibility to provide the Practice with current, accurate insurance information at the time of check in and to notify the Practice of any changes in this information. A valid insurance card(s) and picture ID must be presented at the time of service

- It is the patient's responsibility to obtain insurance carrier coverage limitations.

- If the Practice does not participate with your insurance, you are expected to pay in full for our services at the time of visit. The Practice may provide assistance in filing the charges to your insurance company; however payment is expected up front.

- If you do not have medical insurance, payment for services is required at the time of the visit.

- It is the patient's responsibility to ensure that an authorization and/or referral is obtained prior to your appointment if required by your insurance.

- Patients are billed for any patient responsibility (co-insurance /deductibles/non-covered services) as determined on the Explanation of Benefits (EOB) from your carrier. Patients will receive two (2) statements for any patient balance due after insurance payment. Patients that have not made payment prior to the second statement being mailed are placed in a collection status. Patients with a delinquent balance may be sent to an outside collection service.

- Patients will receive a separate bill from third party laboratories for processing of any laboratory services. Questions about these bills should be directed to the respective lab.

- The Practice does not accept post-dated checks. Checks written to the Practice that are canceled or returned for non-sufficient funds results are assessed a $35.00 fee. To rectify your account, you will be required to pay with cash, money order, cashier's check, or credit card.

- Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

- We request that **you please give our office 24 hour notice in the event that you are unable to keep your appointment**. This courtesy allows us to be of service to other patients. **Failure to comply with this policy will result in a $25 fee for office visits and $100 fee for procedures.**

- Please be advised **that failure to request medications within four (4) business days before your medication runs out will result in a $15 fee to cover the cost of processing the refill request prior to your next scheduled appointment.**

I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits which the patient may be entitled. Patient assigns payment(s), if any, from insurance carriers(s)/health benefit(s) plan to New York Spine & Pain Physicians for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

I understand that if my insurance company or health maintenance organization does not consider the services received as covered or has not authorized the services, then I will be fully responsible for the service provided

Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to call 631-422-6166.

By signing below I certify that I have read and understand the Patient Billing Policy, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient.

____ ________________________________

Patient Name (please print) Date

____ ________________________________

Signature of Patient or Responsible Party Date

____ ________________________________

Witnessed by Practice Representative Date

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In addition to the enclosed paperwork, please bring the following with you to your appointment:

Babylon
500 West Main Street Suite 116
Babylon, NY 11702

Babylon Village
100 West Main Street Suite C
Babylon Village, NY 11702

Bay Shore
8 Saxon Avenue
Suite A
Bay Shore, NY 11706

- ✓ A picture ID
- ✓ Insurance cards
- ✓ Your co-pay (if required by your insurance)
- ✓ Your referral (if required by your insurance)
- ✓ Any report, film, or disc of radiology relating to your pain and treatment
- ✓ Any medical records relating to your pain and treatment
- ✓ A list of medications you are currently taking or their medication bottles

NEW YORK Spine & Pain PHYSICIANS
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**Office use* Provider __________
Appt time ________ Entered _____
Ht _________ Wt_____________
BP____________

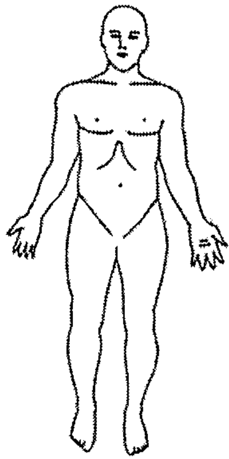
PAIN COMPREHENSIVE QUESTIONNAIRE

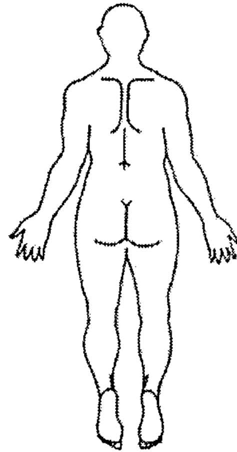
Patient Name ________________________________ **DOB** ________________ **Date** ____________________

Referring Physician ______________________________ **Primary Care Physicians** ________________________________

Chief Complaint (main problem seeking treatment) _______________________________________ **Side** ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:





R L **L R**

Preferred Pharmacy Name/Address:
____

Preferred Pharmacy Phone:
____

Are you pregnant or possibly pregnant?
☐Yes ☐No ☐N/A

---- (0 = no pain 10 = unbearable pain) ----

Pain level today
0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)
0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)
0 1 2 3 4 5 6 7 8 9 10

Allergies
____

Email _________________________________

The onset of your pain was:
☐Motor vehicle accident
Date of Accident __________
Were you wearing a seatbelt: ☐Yes ☐No
Position during the accident:
☐Driver ☐Passenger in front seat ☐Passenger in back seat
☐Falling from a height
☐Injury at work
Date of injury __________
What injury occurred? _________
☐Insidious onset ☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐constantly ☐intermittent ☐worse after activity ☐worse at the end of the day ☐worse during a activity ☐worse during cold seasons ☐worse during the day ☐worse during the night ☐worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: _________________ ☐days ☐weeks ☐months ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Changes in bladder function		Sexual Dysfunction	
Changes in bowel function		Shoulder numbness	
Changes in temperature in the affected area		Suicidal ideation	
Depression		Sweating in affected area	
Finger numbness		Toe numbness	
Flushing in affected area		Hand numbeness	

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PAIN COMPREHENSIVE QUESTIONNAIRE

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
HEAT TREATMENT			
ICE TREATMENT			
ACUPUNCTURE			
MEDICATIONS	Check mark all medication that apply below		

Opioids		NSAIDs/Tylenol		Muscle Relaxants
☐ Tramadol	☐ Methadone	☐ Tylenol	☐ Lodine	☐ Soma
☐ Demerol	☐ Morphine	☐ Aspirin	☐ Orudis	☐ Lorzone
☐ Codeine	☐ Nucynta	☐ Ibuprofen	☐ Relafen	☐ Flexeril
☐ Fentanyl (Duragesic)	☐ Butrans	☐ Naproxen	☐ Celebrex	☐ Baclofen
☐ Hydromorphone (Dilaudid,)	☐ Suboxone	☐ Daypro	☐ Toradol	☐ Zanaflex
☐ Hydrocodone (Vicodin)		☐ Indocin		☐ Robaxin
☐ Oxycodone (Percocet, Oxycontin)		☐ Feldene		☐ Skelaxin
☐ Oxymorphone (Opana)		☐ Voltaren		☐ Valium (Diazepam)

☐ Elavil (Amitriptyline)	☐ Paxil	☐ Neurontin (Gabapentin)	☐ Lyrica
☐ Pamelor (Nortriptyline)	☐ Prozac	☐ Tegretol	☐ Ativan
☐ Desipramine	☐ Serzone	☐ Dilantin	☐ Xanax
☐ Impramine (Tofranil)	☐ Cymbalta	☐ Topamax	☐ Imitrex
☐ Zoloft	☐ Savella	☐ Depakote	☐ Ergotamine
		☐ Klonopin	☐ Mexillitine

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PAIN COMPREHENSIVE QUESTIONNAIRE

Do you have any adverse effects since starting any treatment?
☐Constipation ☐Drowsiness ☐Mental slowness ☐Other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterior	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		Other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic

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INTAKE AND HISTORIES

***** PLEASE COMPLETE THE REMAINDER OF THIS PAPERWORK ON THE PATIENT PORTAL *****

https://nspc.ema.md *****Contact our office at 855-836-7246 for a username and password*****

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other___________________

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other___________________

INTAKE AND HISTORIES

Past Orthopedic History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other___________________

Past Orthopedic Surgery (please check all that apply):

- ☐ Ankle Fracture ORIF
  ☐Right ☐Left ☐Both
- ☐ Carpal Tunnel Decompression
  ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  ☐Right ☐Left ☐Both
- ☐ Intermedullary Nailing Femur
  ☐Right ☐Left ☐Both
- ☐ Intermedullary Nailing Tibia
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder
  ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy
  ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Rotator Cuff Repair
  ☐Right ☐Left ☐Both
- ☐ Other______________________________________
- ☐ **None**

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INTAKE AND HISTORIES

Medications (please list all current medications or check option, which applies):

- Complete the information below regarding all medications you are currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medication, including any herbals or supplements you take.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option, which applies):

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

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INTAKE AND HISTORIES

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other______________

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - __________________

Family History:
Please check appropriate box “Alive” or “Decease” and list ages for the following Blood Family Members. If Parents or Grandparents are deceased, please write in Age and Cause of Death, if known.

	Alive	Age (if known)	Deceased	Age at Death	If deceased, cause of death	Unknown Status
Father						
Mother						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

	Number Alive	Age (if known)	Number Deceased	Age at Death	If deceased, cause of death	Unknown Status
Brothers						
Sisters						
Sons						
Daughters						

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INTAKE AND HISTORIES

Family History (continued):
Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, please mark the box under the relationship of the person to you

				Relationship of Person to you				
	YES	NO	DO NOT KNOW	Father	Mother	Grandparent	Brother /Sister	Son/ Daughter
Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Stroke/TIA								
Alcohol Abuse								
Drug Abuse								
Psychiatric Illness								
Seizures								
Depression/Suicide								
Osteoarthritis								
Osteoporosis								
Scoliosis								
Other Conditions								

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INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Pain w/ breathing		
Joint swelling			Palpitations		
Difficulty Walking			Ankle Swelling		
Muscle Pain			Labored breathing w/exertion		
Weakness			Nausea		
Numbness			Vomiting		
Tingling			Diarrhea		
Fever			Constipation		
Weight Gain			Heartburn		
Rash			Ulcers		
Chest Pain			Blood in Stool		
Incontinence			Urinary Incontinence		
Shortness of Breath			Urinary hesitancy		
Suicidal thoughts			Urinary retention		
Weight loss			Blood in urine		
Chills			Genital pain		
Fatigue			Excessive bruising		
Discoloration			Excessive bleeding		
Scarring			Cancer		
Environmental Allergies			Excessive thirst		
Immunosuppression			Heat/Cold intolerance		
HIV/AIDS			Diabetes		
Blurred Vision			Thyroid Disease		
Double Vision			Joint Stiffness		
Glaucoma			Dizziness		
Eye pain			Fainting		
Ringing in the Ears			Headaches		
Loss of hearing			Tremor		
Nose bleeds			Seizure		
Hoarseness			Memory Loss		
Difficulty Swallowing			Depression		
Cough			Anxiety		
Wheezing			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker			Hepatitis B or C		
Defibrillator			HIV/ADS		
Premedicate Prior to Procedure			Diabetes		
Hepatitis B or C					