Coeur d'Alene Spine and Brain, PLLC

P: 208-765-9100 F: 208-765-9103

Jeffrey J. Larson, M.D. Holly Moore, NP-C Patricia Vieth, PA-C

Date: _____

Referring Physician: _____ **Phone:** ( )_____ **Fax:** ( )_____

Family Physician: _____ **Phone:** ( )_____ **Fax:** ( )_____

Patient (Legal) Name: _____
First MI Last

Mailing Address: _____
City State Zip

Physical Address: _____
City State Zip

Home Ph: ( )_____ **Cell/Work:** ( )_____ **Email:** _____

SSN: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** _____ Male _____ Female

Marital Status: _____ **Preferred Language:** _____

Race: (circle one) American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

Ethnicity: (circle one) Hispanic/Latino Not Hispanic/Latino Unknown Other

Employer: _____ **Occupation:** _____

Employers Address: _____ **Phone:** ( )_____

In case of a medical emergency, who would you like us to notify?

Name: _____ **Phone:** _____

Relationship: _____

Complete if patient has insurance coverage through someone other than their self or is a dependent:

Responsible Party: _____ **Relationship to Patient:** _____

Responsible Party Address: _____
City State Zip

Phone: ( )_____ **Spouse's Name (if Applicable):** _____

Spouse's DOB: _____ **Spouse's SSN:** _____ **Spouse's Employer:** _____

Is this visit a result of an injury? Yes / No **Date of Injury:** _____

Is this work related? Yes / No **Other:** _____

Attorney (if applicable): _____ **Attorney Ph:** ( )_____

Insurance Information: Please read the following sections carefully.

Medicare Patient Only:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coeur d'Alene Spine and Brain, PLLC for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

Primary Insurance Company: _____ **Phone:** _____

Name of the Primary on Insurance: _____ Soc. Sec. Number: _____

Date of Birth for Primary on Insurance: _____ Relationship to Patient: _____

Insurance Address: _____

Policy #: _____ **Group #:** _____

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

Secondary Insurance Company: _____ **Phone:** _____

Name of Insured: _____ Soc. Sec. Number: _____

Insurance Address: _____

Policy #: _____ **Group #** _____

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

Worker's Compensation Information:

Carrier: _____ Claim #: _____

Claim Office Address: _____

Adjuster: _____ Phone: _____

Date of Injury: _____ Employer: _____

Are you represented by an attorney? [ ] Yes [ ] No
Name of attorney: _____ Phone: _____

I authorize Coeur d'Alene Spine and Brain, PLLC to appeal claims on my behalf when deemed necessary.

Signature: _____ Date: _____

Coeur d'Alene Spine and Brain, PLLC

Policies Acknowledgement Form

Please read the following information regarding your care and patient responsibility at Coeur d'Alene Spine and Brain. You will be asked to sign on the second page indicating you have read and understand the policies, procedures and your financial responsibility as a patient.

Patient Name: _____ DOB: _____

Patient Financial Responsibility

Coeur d'Alene Spine and Brain appreciates the confidence you have shown in choosing us to provide for your health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Coeur d'Alene Spine and Brain, PLLC is contracted with the following: **Medicare, Medicaid of Idaho, Blue Cross of Idaho, Regence Blue Shield of Idaho (We are NOT contracted with Regence Med Advantage Plans), First Choice Health Network, Group Health (Dr. Michael Ludwig and Imaging Services ONLY), WA L&I (Imaging Services ONLY).**

*****IF YOUR INSURANCE IS NOT INCLUDED ON THE LIST ABOVE YOUR SERVICES WILL MOST LIKELY APPLY TO YOUR OUT OF NETWORK BENEFITS. IT IS STRONGLY RECOMMENDED THAT YOU CONTACT YOUR INSURANCE TO VERIFY YOUR COVERAGE AND BENEFITS PRIOR TO YOUR VISIT. *****

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Prescription Refill Policy

Coeur d'Alene Spine and Brain providers will not fill prescriptions after set hours or on weekends. Post-surgical patients will receive prescriptions for a set period of time depending on their surgery and their adherence to the prescription directions. After this time period it is the patient's responsibility to make any necessary arrangements with their primary care physician for any further refills. NOTE: New law mandates that narcotic medications will only be filled with a written prescription. We are no longer able to call in these types of prescriptions. Prescriptions will need to be picked up in the office by the patient, unless the patient has notified the office in writing of their request to allow another individual to pick up the prescription. In those instances, the authorized individual will need to bring in their ID in order to pick up the prescription. Patient's picking up their own prescription will also need to bring a valid photo ID in order to pick up the prescription. It is your responsibility as a patient to manage when you will need a refill and notify the office in a timely fashion. Refills for non-narcotic medications should be phoned into the pharmacy to request any needed refills. Prescription refills will only be filled in accordance with the office policy (which is posted and may be subject to change). Please take time at each office visit to ensure that you are current on any prescription policy changes (both state mandated and internal).

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Cancellation/ No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancelling your appointment. Patient's who "no show" without advance warning for two consecutive appointments may be discharged from care. Coeur d'Alene Spine and Brain will notify you in writing, via certified mail, if you are discharged from care.

Self-Pay

Patient's that do not have health insurance will be responsible for payment of services rendered here at Coeur d'Alene Spine and Brain. The patient will be responsible to pay Coeur d'Alene Spine and Brain the full and entire amount of treatment given to them or to the above named patient at each visit.

Patient Initials: _____ Date: _____

Coeur d'Alene Spine and Brain, PLLC

Policies Acknowledgement Form

Motor Vehicle Insurance (PIP)

Patient's wishing to file claims through a motor vehicle carrier, are responsible for ANY bills incurred that are not covered and/or paid for using the PIP benefit through the motor vehicle insurance.

Self Referral Notice (Imaging Services)

Pursuant to Section 6003 of the Patient Protection and Affordable Care Act (PPACA), with respect to referral for magnetic resonance imaging (MRI), the referring physician must inform a patient in writing at the time of the referral that a patient may obtain the service from a person other that the referring physician or someone in the physician's group practice. Coeur d'Alene Spine and Brain is pleased to be able to provide you with convenient and timely scheduling of your MRI. Having the capability of an ACR accredited MRI in-house has allowed our physicians to treat patient's more quickly, conveniently and competently at a competitive price. We take pride in delivering high quality services. There are other medical facilities in our immediate area that provide similar services. Kootenai MRI 2003 Kootenai Health Way, Coeur d'Alene ID 83814 (208) 666-2190 (Joint venture with KMC) ; Kootenai Outpatient Imaging 700 Ironwood Dr. Ste. 110, Coeur d'Alene ID 83814 (208) 666-3200 (Joint venture with KMC) ; Kootenai Outpatient Imaging-Post Falls 1300 E Mullan Ave. Ste. 700, Post Falls ID 83854 (208) 777-1305 (Joint venture with KMC), Northwest Specialty Hospital 750 N Syringa, Post Falls ID 83854 (208) 262-2390. If you would like to receive services at another facility, please notify our staff and they will be happy to provide you with a referral.

Self Referral Notice (Pleasant View Surgical Center)

Pursuant to Section 6002 of the Patient Protection and Affordable Care Act (PPACA), with respect to transparency reports and reporting of physician ownership or investment interests, CDA Spine and Brain would like you to be aware that Pleasant View Surgery Center is owned in part by physicians. Jeffrey Larson, M.D. and Michael Ludwig, M.D. are part owners in the surgery center. CDA Spine and Brain providers may choose to refer you to have your surgery/procedure done at Pleasant View Surgical Center and may also be performing your surgery or other services in connection with your referral. Please discuss this matter with your physician so that you may exercise your right to be treated in another health care facility if desired. Upon your request, your physician will provide names and addresses of alternative facilities where you may go to obtain services.

Consent for Treatment and Authorization to Release Information

I am aware that by signing below, I authorize Coeur d'Alene Spine and Brain, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I also authorize Coeur d'Alene Spine and Brain, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

To help protect our patient's privacy, Coeur d'Alene Spine and Brain requires patient's to sign a medical records release prior to releasing any records. We understand that there are situations where another medical provider might need pertinent information in order to expedite your medical care. To help you receive timely care, Coeur d'Alene Spine and Brain will release medical information via verbal and written requests from other physician's offices without a signed release.

By signing below, I am aware that Coeur d'Alene Spine and Brain will do their best to protect my confidential information, but I understand that it is possible for someone to misrepresent themselves by telephone and/or forgery and that my right to privacy may be compromised.

Notice of Privacy Practices (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Lisa R. Tansy, Administrator. Our Notice of Privacy Practices (HIPAA) describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a copy for your records you may request one from the front desk or you may download a copy on our website www.cdaspine.com.

I hereby authorize that I have read the Coeur d'Alene Spine and Brain Policies Acknowledgement Form in its entirety (2 pages) and understand my responsibilities and options as a patient.

Patient Signature: _____ Date: _____

Guarantor Signature : _____ Date: _____

(if guarantor is not the patient)

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical records. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plan(s), and my other healthcare provider(s).

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Printed Name Relation

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Today's Date: _____

ID Number: _____

Patient: _____

Claim #: _____

Provider: _____

Date of Serv: _____

Incident Report

Please complete this Incident Report and return it in the enclosed envelope within 45 days of receipt. If we do not receive your complete and signed Incident Report within forty-five days, all claims related to this incident will be denied until the Incident Report is received. Please be aware that if claims are denied due to tardiness in returning your completed Incident Report, charges billed by your provider will be considered your responsibility and the provider may bill you directly for these expenses.

Complete information is essential and very much appreciated. When additional information is required, claims cannot be processed. It will take up to 15 days after we receive all necessary information before claims can be processed. To avoid delays, carefully and completely provide all requested information.

GENERAL INFORMATION

Briefly explain why you sought treatment. Please identify the specific body area(s) affected by this injury, if applicable. How did the injury occur? What was injured? Where did the event occur?

Date of injury or onset of illness_____ Explanation_____

_____

Was the service received for the injury described above related to an incident that occurred:

- ☐ At work or on the job; or
- ☐ Due to an auto accident or auto-related injury; or
- ☐ Due to an Other Vehicle Accident (motorcycle, scooter, snowmobile, boat, etc. accident); or
- ☐ Caused by another party; or
- ☐ Caused by something/someone at a business or residence other than your own home?

The service received from the injury described above:

- ☐ Was not incurred at work or on the job; or
- ☐ Was not caused by another party or incurred as the result of an accident; or
- ☐ No other person was involved. Please explain above.

If the injuries you sustained were not related to an accident or incurred at work or on the job, please skip to the end of this form and sign, date and return it to us.

Otherwise, please continue on and complete the applicable section(s) on pages 2 and 3, then sign, date and return the form.

GENERAL INFORMATION (continued)

Do you intend to seek recovery for damages from the party responsible for the accident, injury or work-related condition? ☐ **Yes** ☐ **No**

Have you been offered a settlement? ☐ Yes ☐ No
Have you accepted a settlement? ☐ Yes ☐ No

If Yes, date of settlement _____ Amount of settlement _____
Please include a copy of your settlement documents

Have you hired an attorney? ☐ **Yes** ☐ **No**

Attorney's Name _____ Phone Number _____

Attorney's Address _____

Was the treatment a result of an auto/other type of vehicle injury/accident?
☐ **Yes (please give details below)** ☐ **No**

The patient was a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other
The vehicle was a: ☐ Car ☐ Motorcycle ☐ ATV ☐ Snowmobile ☐ Other

Were there more than two vehicles involved? ☐ Yes ☐ No

Name of the At-Fault Party _____

At-Fault Party's Insurance Company _____

At-Fault Party's Insurance Company's Address _____

_____

Adjuster's Name _____ Adjuster's Phone Number _____

Claim Number _____ Adjuster's E-mail Address _____

Do you have vehicle insurance? ☐ Yes ☐ No *If No, attach a copy of police report.

Is there Personal Injury Protection (PIP) or Medical Payments (Med-Pay) under your vehicle insurance?
☐ **Yes** ☐ **No** Please attach a photocopy of your insurance policy declaration page that shows what types of coverage you have (in particular, whether your policy provides PIP or Med-Pay coverage) and the monetary amount of your coverage.

Name of your Insurance Company _____

Insurance Company's Address _____

Adjuster's Name _____ Adjuster's Phone Number _____

Claim Number _____ Adjuster's E-mail Address _____

Name of other family member(s) covered on your health plan that were injured _____

_____

GENERAL INFORMATION (continued)

If accident was not in your own vehicle, name and address of owner of vehicle in which patient was traveling.

_____

Insurance Company, Claim Number, Adjuster's Name and Phone Number for vehicle in which patient was traveling.

Did this vehicle policy have PIP or Med-Pay benefits for passengers? ☐ Yes ☐ No

***If PIP/Med-Pay is exhausted, please provide copy of auto insurance payment ledger.**

WORK-RELATED CONDITION

Was the service you received necessitated by an injury, condition, or illness caused or received at work or on the job? ☐ Yes ☐ No

If Yes, please tell us what happened _____

_____

When (or over what period of time) did you incur your injury or illness _____

Have you filed a claim with Workers' Compensation? ☐ Yes ☐ No

If Yes, please provide: Claim Number _____

Workers' Compensation Carrier Name, Address _____

_____

Adjuster's Name _____ Adjuster's Phone Number _____

***If your claim was denied or closed, please attach a copy of your closure notice or denial.**

Do you plan to appeal this decision? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No

If Yes, do you carry an industrial policy for yourself? ☐ Yes ☐ No

Name and Address of Industrial carrier (if applicable) _____

_____

OTHER ACCIDENT OR INJURY

Did the accident or injury occur on someone else's property? ☐ Yes ☐ No

Do the property owners have insurance to cover medical expenses? ☐ Yes ☐ No

Do you intend to file a claim? ☐ Yes ☐ No

If Yes, please provide the name of the insurance company _____

Adjuster's Name _____ Claim Number _____

Address Phone Number _____

_____

SUBSCRIBER STATEMENTS

I understand that if I, or any of my covered dependents ("Subscriber") have been in an accident or have been injured by another party, or have work-related condition, the benefits of my health benefit plan will be available to me or my covered dependents, subject to the terms, limitations, and exclusions of the plan. The Subscriber further understands that as a condition of coverage, the health benefit plan requires the Subscriber to cooperate with the insurance carrier in its efforts to recover the cost of benefits it has provided from the responsible party or the responsible party's insurer, and that if the Subscriber does not cooperate in full accordance with the health benefit plan, that the insurance carrier may pursue reimbursement from the responsible party, or the responsible party's insurer, or from the Subscriber in accordance with the health benefit plan and applicable law.

The Subscriber understands that the insurer and anyone acting on its behalf is permitted by law to release information about any accident, injury, or work-related condition described on the Incident Report and the benefits and medical service the Subscriber received in connection with that accident, injury or work-related condition to any potentially responsible party and the potentially responsible parties' insurer.

The Subscriber authorized the insurance company(ies) listed on pages 2 and 3 to release any information concerning the Subscribers coverage to the insurer. The Subscriber further authorizes to review the Subscriber's workers' compensation claims files pertaining to this Incident Report so that the insurer can determine whether workers' compensation coverage is available for any potential work-related condition.

The Subscriber understands that it is a crime to knowingly provide false, misleading, or incomplete information to the insurer with the intent of defrauding the company, and that the penalties for committing fraud include imprisonment, fines and denial of insurance benefits. Moreover, the insurer will have the right to pursue its legal rights, including the collection of claims payments and any other damages.

The Subscriber accordingly declares that the information on pages 1 through 3 is true, correct and complete.

DATE and SIGNED on the _____ day of _____, 20_____.

Home Phone Number_____ Work Phone Number _____

Cell Phone Number_____ Email Address_____

SUBSCRIBER SIGNATURE:_____

Date_____ Insurance ID Number _____

Injured Dependent/Guardian Signature_____

Date_____ Relationship_____

We (the insurer) may need to contact you further to clarify your answers or obtain additional information. Please include available times if there are time restrictions regarding when you should be contacted.

Additional information/clarification_____

_____

_____

CDA Spine New Patient History Form

Legal Name: _____ **Age**: _____

How did you find us? □ Chiropractor □ Therapist □ Friend/relative □ Internet
□ Doctor referral _____ □ Other _____

1. My current pain developed: □ Gradually □ Suddenly Date of onset ___/___/_____

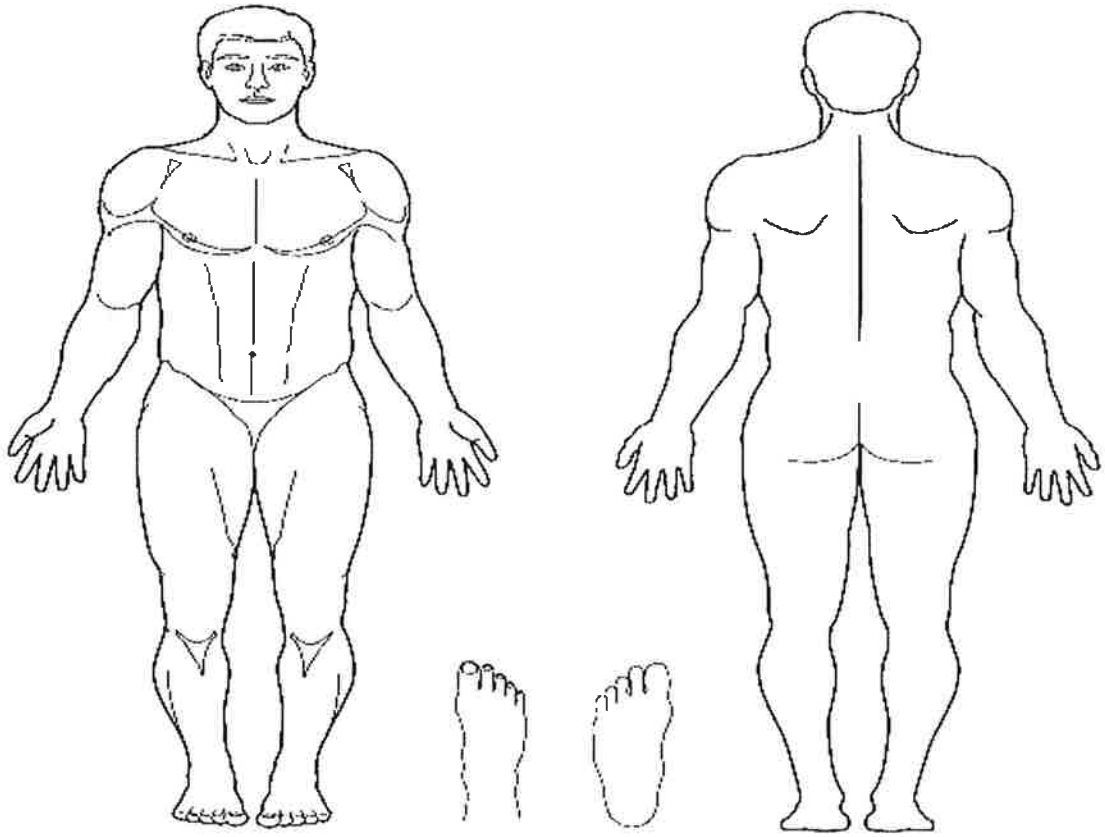
□ Motor vehicle accident Attorney: _____
□ Work injury: Date of injury _____/____/_____

2. Please make a mark on the line below to show your average pain level over the past week.

No Pain 0_____5_____10 Worst Pain Imaginable

Please use the following key to shade in the distribution of your pain on the figures:

Numbness ..... **Pins and Needles** 00000000 **Pain** ////////////////



3. My pain is best described as (check all that apply): □Constant □Intermittent

□Dull □Sharp □Throbbing □Burning □Tingling
□Aching □Stabbing □Shooting □Electrical

4. My pain is worse with (check all that apply): □ Bending forward □ Bending backward

□ Sitting □ Standing □ Walking □ Laying down
□ Looking up □ Looking down □ Turning left □ Turning right
□ Cough/Sneeze □ Lifting □ Pushing/pulling

5. **My pain is better with:** □ Laying down □ Sitting □ Standing □ Therapy
□ Changing positions □ Pain meds □ Ice □Heat □ Nothing

6. **Have you experienced new bowel or bladder leakage/accidents recently?** □ Yes □ No

7. **Have you had any of the following tests for the current problem in the last 2 years?**
□ X-rays □ CT scan □ MRI □ EMG □ Bone scan
□ Diagnostic Spinal Injections (e.g. epidural, facet/sacroiliac joint block, discogram)

8. **Have you tried the following treatments for my pain** (Circle those that helped):
□ Physical Therapy □ Chiropractic □ Acupuncture □ Massage
□ Spinal Injections □ Surgery □ Traction □ Home/gym exercises

Place of Service: _____

9. **Have tried the following medications for my pain** (Circle those that helped, X out those that didn't):
Anti-inflammatories (Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, Diclofenac, Steroids)
Muscle relaxants (Soma, Flexeril, Carbamazepine, Zanaflex, Skelaxin, Robaxin, Methocarbamol)
Anti-seizure drugs (Neurontin, Gabapentin, Lyrica)
Anti-depressants (Paxil, Zoloft, Nortriptyline, Amitriptyline)
Narcotics (Lortab, Hydrocodone, Oxycodone, Oxycontin, Ultram, Vicodin, Percocet, Methadone)

10. **Medication Allergies**: □ None □ Iodine □ Contrast dye □ Steroids □ Local Anesthetics
□ Latex □ Other: _____
Allergic Reaction that occurred: _____

11. **Are you currently taking any blood thinning/anticoagulation medications?** □ YES □ NO
(Coumadin, Warfarin, Pradaxa, Plavix, Aggrenox, Aspirin, Flax seed, Fish Oil etc.)

12. **Pertinent Medications:** _____
_____

13. **Medical History**: Please check the following medical problems you have now, or have had:

□ Anemia	□ Thyroid problems	□ Easy bleeding	□ Osteoarthritis
□ Asthma	□ Epilepsy	□ Colon disease	□ Ulcers
□ Cancer	□ Migraines	□ High blood pressure	□ Kidney problems
□ Stroke	□ Depression	□ Hepatitis/HIV	□ Bladder problems
□ Anxiety	□ Osteoporosis	□ Fibromyalgia	□ Lung Disease
□ Heart problems	□ Diabetes	□ Rheumatoid arthritis	□ Vascular problems
Explain: _____	Type: _____		

□ Other: _____

Have you had previous back or neck problems? □*Yes* □*No*
Have your received care from a mental health professional? □*Yes* □*No* □*Still seeing*_____
Have you ever had an infection with MRSA? □Yes □No

14. **Surgical History**: Spine surgery? □ None □ Neck/Cervical □ Mid-back/ Thoracic Spine □ Low back/lumbar
Orthopedic surgery? □ None □ Shoulder □ Elbow □ Wrist □ Hand □ Hip □ Knee □ Ankle □ Foot
Heart surgery or lung surgery? □ Yes □ No Cardiac or peripheral stents? □ Yes □ No

15. **Family History**: Please check those illnesses that your family members have had

	Hypertension	Diabetes	Neurologic Problems	Heart Disease	Cancer	Arthritis
Father	□	□	□	□	□	□
Mother	□	□	□	□	□	□
Siblings	□	□	□	□	□	□
Grandparents	□	□	□	□	□	□

Father: □ *Living* □ *Deceased (Age)* ____ Mother □ *Living* □ *Deceased (Age)* ____

16. **Social History**: Do you now, or did you ever smoke? □ No □ Yes Packs per day?_____ Quit?_____
Do you drink alcohol?_____ □ No □ Yes □ daily □ rarely
Do you now, or have you ever had a drug or alcohol problem? □ No □ Yes
Please explain: _____
Marital Status: □ Single □ Married □ Divorced □ Widowed

17. **Vocational History**:
□ Employed Full Time □ Employed Part time □ Retired □ Regular Duty
□ Light Duty □ Disability (reason)_____
Employer: _____
Job Description: _____
Years at current job: _____ Date last worked:_____
Rate your current job satisfaction: □ Very Satisfied □ Satisfied □ Indifferent □ Dissatisfied
Have you ever been on disability? □ No □ Yes: _____
How physically demanding is your job? Check one.
□ Very heavy (lifting > 100 pounds) □ Heavy (lifting > 60 pounds) □ Moderate (lifting > 30 pounds)
□ Light (lifting > 10 pounds) □White collar (no lifting)

18. **Review of Systems**: Please check any of the symptoms you have had during the past year.

□ Fever	□ Chills	□ Unintentional weight loss of >10 #	
□ Rashes	□ Skin infections	□ Itching of skin	
□ Cataracts	□ Glaucoma	□ Double vision	□ Loss of vision
□ Ear infections	□ Mouth sores	□ Sore throat	□ Nasal congestion
□ Chest pain	□ Leg swelling	□ Irregular heart beat	
□ Short of breath	□ Cough	□ Wheezing	
□ Nausea	□ Vomiting	□ Abdominal pain	
□ Blood in urine	□ Painful urination	□ Difficulty urinating	
□ Dizziness	□ Seizures	□ Ringing in ears	□ Memory loss
□ Face numbness	□ Arm numbness	□ Leg numbness	□ Sudden weakness
□ Joint pain	□ Muscle pain	□ Difficulty walking	
□ Depression	□ Anxiety	□ Hallucinations	
□ High blood sugar	□ Thyroid disorder	□ Anemia	

The information I have provided in this document is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____