Joint Regeneration & Anti-Aging of Peachtree City

Patient Tracking Report

Name: _____ DOB: ____/____/_____

Height: _____Ft_____In Weight: _____Lbs BMI: _____

Date	Vitals	X-ray	Exam	Arthro	Brace	HA Rt	HA Lt	PRP	Amnio
	BP: P: T: R:								
	BP: P: T: R:								
	BP: P: T: R:								
	BP: P: T: R:								
	BP: P: T: R:								
	BP: P: T: R:								
	BP: P: T: R:								
	BP: P: T: R:								
	BP: P: T: R:								
	BP: P: T: R:								

Patient name_____ DOB_____ Date_____

Leg/Knee Measurement and Assessment

	RIGHT		LEFT	
Exam	Valgus	Vargus	Valgus	Vargus
X-ray	Medial	Lateral	Medial	Lateral
Measurement	U UM	LM L	U UM	LM L
ROM	Ex Flex		Ex Flex	
Normal **Abnormal**	Ex Flex Ex **Flex**		**Normal Range** **Extension 120-0** **Flexion 0-130**	

Demographic Information

Date: _____

First Name: M.I. Last Name: _____

Address: _____ City:_____

State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

SS#: _____ Age: _____ Date of Birth:_____

Gender: Male/Female _____

Primary Care Physician: _____ Office Phone #: _____

Do we have your permission to contact your physician regarding your care in our office?
(Please circle one) Yes / No

Your preferred method of contact for appointment reminders:
(Please circle one) Email / Text Message / Phone

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone #: _____

Smoking Status:
(Please circle one) Never / Formerly (if so, how many years) ___ / Current Smoker

Preferred Language: _____

Race: _____

Ethnicity: _____

How did you hear about this office? _____

Do you have health insurance? _____ Policy #: _____

Secondary insurance? _____ Policy #: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on **April 19, 2021** and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, **Kristyn Manzi**
Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013, immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $ 0 for each page and the staff time charged will be $ 0 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

~~**Fundraising:** We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include diagnosis, nature of services and treatment. If you have elected to opt out, we are prohibited from making fundraising communication under the HIPAA Privacy Rule.~~

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ 0 for each page and the staff time charged will be $ 0 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change,

By signing below, you indicate that you have read and understand the rights and responsibilities outlined in this document. To see our full HIPAA Notice of Privacy, you may request a paper copy or go to jointregenmedptc.com/privacy. We will never sell or disclose any of your personal information.

Signature of Patient or Legal Representative	Date
Printed Name of Patient	Legal Relationship to the Patient *(If required)*

Joint Regeneration & Anti-Aging of Peachtree City

Consent to X-rays

Adult Male:

I hereby authorize the performance of a diagnostic x-ray. The provider has requested an x-ray for further diagnostic purposes. At this time, I know of no other condition that an x-ray would further complicate.

Signed: _____ Date: _____

Adult Female:

This is to certify that, to the best of my knowledge, I am NOT pregnant. The provider has my permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: _____ Date: _____

Minor:

I, the parent or legal guardian of the patient, hereby authorize the performance of a diagnostic x-ray. The provider has requested an x-ray for further diagnostic purposes. At this time, I know of no other condition that an x-ray would further complicate.

Signed: _____ Date: _____

The Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)

Name: _____ **Date:** _____

Instructions: Please rate the activities in each category according to the following scale of difficulty: 0 = None, 1 = Slight, 2 = Moderate, 3 = Very, 4 = Extremely

Circle one number for each activity		
Pain	1. Walking	0 1 2 3 4
	2. Stair climbing	0 1 2 3 4
	3. Nighttime	0 1 2 3 4
	4. Rest	0 1 2 3 4
	5. Weight-bearing	0 1 2 3 4
Stiffness	1. Morning stiffness	0 1 2 3 4
	2. Stiffness occurring later in the day	0 1 2 3 4
Physical Function	1. Descending stairs	0 1 2 3 4
	2. Ascending stairs	0 1 2 3 4
	3. Rising from sitting	0 1 2 3 4
	4. Standing	0 1 2 3 4
	5. Bending to floor	0 1 2 3 4
	6. Walking on flat surface	0 1 2 3 4
	7. Getting in/out of car	0 1 2 3 4
	8. Going shopping	0 1 2 3 4
	9. Putting on socks	0 1 2 3 4
	10. Lying in bed	0 1 2 3 4
	11. Taking off socks	0 1 2 3 4
	12. Rising from bed	0 1 2 3 4
	13. Getting in/out of bath	0 1 2 3 4
	14. Sitting	0 1 2 3 4
	15. Getting on/off toilet	0 1 2 3 4
	16. Heavy domestic duties	0 1 2 3 4
	17. Light domestic duties	0 1 2 3 4

Total Score: _____ / 96 = _____ %

Comments / Interpretation (to be completed by therapist only).

The Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)

Name: _____ **Date:** _____

Instructions: Please rate the activities in each category according to the following scale of difficulty: 0 = None, 1 = Slight, 2 = Moderate, 3 = Very, 4 = Extremely

Circle one number for each activity		
Pain	1. Walking	0 1 2 3 4
	2. Stair climbing	0 1 2 3 4
	3. Nighttime	0 1 2 3 4
	4. Rest	0 1 2 3 4
	5. Weight-bearing	0 1 2 3 4
Stiffness	1. Morning stiffness	0 1 2 3 4
	2. Stiffness occurring later in the day	0 1 2 3 4
Physical Function	1. Descending stairs	0 1 2 3 4
	2. Ascending stairs	0 1 2 3 4
	3. Rising from sitting	0 1 2 3 4
	4. Standing	0 1 2 3 4
	5. Bending to floor	0 1 2 3 4
	6. Walking on flat surface	0 1 2 3 4
	7. Getting in/out of car	0 1 2 3 4
	8. Going shopping	0 1 2 3 4
	9. Putting on socks	0 1 2 3 4
	10. Lying in bed	0 1 2 3 4
	11. Taking off socks	0 1 2 3 4
	12. Rising from bed	0 1 2 3 4
	13. Getting in/out of bath	0 1 2 3 4
	14. Sitting	0 1 2 3 4
	15. Getting on/off toilet	0 1 2 3 4
	16. Heavy domestic duties	0 1 2 3 4
	17. Light domestic duties	0 1 2 3 4

Total Score: _____ / 96 = _____ %

Comments / Interpretation (to be completed by therapist only).

Joint Regeneration & Anti-Aging

Patient Medical History Form

Print Name: _____ Date of Birth: _____

Please list any drug allergies:

_____

Occupation: _____

Please list the reason(s) for today's visit:

1. _____
2. _____
3. _____

Medication Name	Dosage Strength (mg)	Directions (take # per day)	Prescribed by:
Example: Tylenol	Example: 500 mg	Example: 2 tablets once daily	Physician's Name

Additional Medications Continued:

Medication Name	Dosage Strength (mg)	Directions (take # per day)	Prescribed by:
Example: Tylenol	Example: 500 mg	Example: 2 tablets once daily	Physician's Name

Dear Patient:

A new requirement for medical practices is to assess your potential risk for falls. Please complete the following:

FALL RISK ASSESSMENT

Have you fallen in the last year?	YES	NO
Do you lose your balance when standing?	YES	NO
Do you lose balance when initially getting up from sitting	YES	NO
Do you get dizzy, faint or have seizures?	YES	NO
Does it take you more than one try to get up out of a chair or out of bed?	YES	NO
Do you trip over your own feet or objects on the floor?	YES	NO
Do you take corners too sharp; bump into corners or door frames?	YES	NO
Do you use a walker, cane or need assistance to get around?	YES	NO

Osteoarthritis Subjective/HPI

Print Name: _____ Date of Birth: _____

Allergies to Medications/Dyes: _____

Chief Complaint: (check all that apply) ☐ Right knee ☐ Left knee

☐ Pain ☐ Stiffness ☐ Mobility ☐ Instability

When did probem/pain begin? _____

Precipitating event/injury? ☐ None ☐ Running ☐ Climbing ☐ A fall ☐ Squatting

☐ Lifting ☐ Motor vehicle accident ☐ Lifting ☐ Other_____

Pain level: (0 = no pain, 10 = worst pain) **Average:** _____ **Worst:** _____

What makes pain worse? (check all that apply) ☐ Sitting ☐ Standing ☐ Walking ☐ Getting dressed

☐ Going up stairs ☐ Going down stairs or incline ☐ Carrying +10 pounds ☐ Driving ☐ Dancing

☐ Working ☐ Laying down ☐ Jumping ☐ Knelling ☐ Squatting ☐ Extending knee straight ☐ bending

What makes pain better? (check all that apply) ☐ Aspirin ☐ NSAID's (e.g. Advill,/Motrin,/Aleve

☐ Heat ☐ Ice ☐ Rest ☐ Knee elevation ☐ Extending the knee ☐ Bending the knee ☐ Nothing

Frequency of symptoms:

☐ Constant (76-100% of the day) ☐ Frequent (51-75% of the day)

☐ Occasional (26-50% of the day) ☐ Infrequent (1-25% of the day)

Nature of symptoms: (check all that apply)

☐ Sharp ☐ Shooting ☐ Dull ☐ Numbness ☐ Tingling ☐ Burning ☐ Radiating ☐ Throbbing

☐ Aching ☐ Stabbing ☐ Clicking ☐ Knee gives out ☐ Locking ☐ Swelling ☐ Stiffness

Mechanism of injury or pain:

☐ Gradual onset ☐ Sudden onset ☐ traumatic

I am able to walk:

☐ < 5 minutes ☐ < 10 minutes ☐ < 15 minutes ☐ < 30 minutes ☐ 30 minutes

☐ 45 minutes ☐ One hour ☐ Only a few steps ☐ Around the house only

I have tried and failed with conservative therapy of at least 90 days e.g. (including dates)

- ☐ NSAID (anti-inflamatories, i.e aspirin, Advil, Motrin, Celebrex) Dates: _____
- ☐ Acetaminophen (i.e. Tylenol) Dates: _____
- ☐ Topical creams (i.e. Diclofenac, Voltaren) Dates: _____
- ☐ Weight reduction (if overweight) Dates: _____
- ☐ Cardiovascular (aerobic) activity such as: walking, biking, stationary bike, aquatic exercise Dates: _____
- ☐ Physical therapy Dates: _____
- ☐ Occupational therapy Dates: _____
- ☐ Participation in self-management programs Dates: _____
- ☐ Wear of medically directed patella taping Dates: _____
- ☐ Thermal agents Dates: _____
- ☐ Walking aids Dates: _____
- ☐ Resistance exercise Dates: _____

Patient Name: _____ **DOB:** _____

RIGHT KNEE

Surgical History:

☐ Arthroscopic surgery ☐ Total knee replacement

History of previous injections

☐ Steroid injections Date: _____

☐ Hyaluronic acid injections Date: _____

If prior injections, did you get pain relief? ☐ Yes ☐ No ☐ Partial

Additional notes:

_____

_____

_____

Last imaging (x-ray/MRI): _____

LEFT KNEE

Surgical History:

☐ Arthroscopic surgery ☐ Total knee replacement

History of previous injections

☐ Steroid injections Date: _____

☐ Hyaluronic acid injections Date: _____

If prior injections, did you get pain relief? ☐ Yes ☐ No ☐ Partial

Additional notes:

_____

_____

_____

Last imaging (x-ray/MRI): _____

Patient Signature: _____ Date: _____

Discussed/Reviewed by Provider: _____ Date: _____

Family History: **F**-Father **M**-Mother **C**-Children **S**-Sister **B**-Brother **FF**-Father's Father **FM**-Father's Mother **MF**-Mother's Father **MM**-Mother's Mother

Alcoholism _____
Asthma _____
Bleeding Disorder _____
Cancer and Type _____
Depression/Anxiety _____
Diabetes _____
Glaucoma _____
Hair Loss _____
Heart Disease _____
High Blood Pressure _____

Kidney Disease _____
Mental Illness _____
Migraines _____
Osteoporosis _____
Seizures/Epilepsy/Convulsions _____
Stroke _____
Thyroid Disease _____
Other _____
Other _____
Other _____

Social History: Smoker ____ Former Smoker _____ Never Smoked _____ How many years? _____
Cigarettes: ___ Yes ___ No How many/how much per day: _____
Smoke for how many years: _____ (Age started: _____ Age quit: _____)
Tobacco: Dip/Snuff/Chew: ___ Yes ___ No Amount per day: _____ (Age started: _____ Age quit: _____)
eCigs or Vaporizers: ___ Yes ___ No Other: _____
Recreational Drug Use: ___ Yes ___ No If yes, please state type: _____
Alcohol: ___ Yes ___ No Type: _____ How much: _____ How often: _____

Please list all additional medical providers and approximate date of last visit with them.

Family/primary care: _____
Cardiologist (heart/vascular): _____
Orthopedic (bones & joints): _____
Chiropractor: _____
Pain management: _____
Physical therapy: _____
Home health: _____
Other: _____

Patient Past/Current Medical History: Please check if you <u>have ever had</u> any of the following:

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy shots
- ☐ Anemia
- ☐ Asthma/wheezing
- ☐ Blood pressure: (high or low)
- ☐ Bronchitis
- ☐ Chemical dependency
- ☐ Depression
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heartburn
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ Kidney problems
- ☐ Migraines
- ☐ Mouth sores or bleeding
- ☐ Nosebleeds
- ☐ Pinched nerve
- ☐ Prostate problems
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Tonsilitis
- ☐ Typhoid Fever
- ☐ Venereal Disease
- ☐ Whooping cough
- ☐ Other_____

- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Bad breath/taste
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Broken bones
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Dry skin
- ☐ Ear infections
- ☐ Fybromyalgia
- ☐ Fractures
- ☐ Gallbladder
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart attack
- ☐ Heart problems
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Herniated disc
- ☐ Herpes
- ☐ Hormone/gland problems

- ☐ Insomnia
- ☐ Liver disease
- ☐ Measles
- ☐ Menopausal
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Polio
- ☐ Prosthesis
- ☐ Psychiatric care
- ☐ Scarlet Fever
- ☐ Sexual difficulty
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ TMJ pain
- ☐ Tremors
- ☐ Tuberculosis
- ☐ Tumors/growths
- ☐ Ulcers
- ☐ Vaginal infections

Are you currently under medical care? If yes, with whom and for what medical conditions?

_____

_____

_____

Initial as Reviewed by Provider: _____

Review of Symptoms: Please check any symptoms you've had (over the last three months).

GENERAL	Yes	No	EAR, NOSE, THROAT	Yes	No
Fever			Hearing Loss		
Night sweats			Ringing in the ears		
Hot flashes			Dizziness or vertigo		
Temperature intolerance			Bleeding gums		
Excessive thirst			Nosebleeds		
Fatigue					
Sleep difficulties					
Daytime sleepiness					
Unplanned weight change					

SKIN	Yes	No	CARDIOVASCULAR	Yes	No
Rash			Chest pain		
Skin changes			Heart murmur		
New or changing moles			Irregular heart beat		
			Palpitations		
			Led swelling or edema		

EYES	Yes	No	PULMONARY	Yes	No
Pain			Wheezing		
Redness			Chronic cough		
Vision change			Shortness of breath		

HEMATOLOGICAL	Yes	No	GASTROINTESTINAL	Yes	No
Swollen lymph nodes			Diarrhea/constipation		
Blood clots			Indigestion/heartburn		
Excessive bleeding			Nausea		
Anemia			Blood in stool		

Initial as Reviewed by Provider: _____

NEUROLOGICAL	Yes	No	PSYCHOLOGICAL	Yes	No
Abnormal gate (trouble walking)			Anxiety		
Falls often			Depression		
Headache severe and/or frequent			Memory loss		
Seizures			Mood swings		
Muscle weakness					
TIA or stroke					
Fainting					
Loss of consciousness					
Numbness, tingling or neuropahty					

GENITOURINARY	Yes	No	MUSCULOSKELETAL		
Pain or burning on urination			Generalized body pain		
Frequent urination			Joint pain		
Waking to urinate more than once at night			Stiffness		
			Joint swelling		
Excessive urination			Joint redness		
Difficulty emptying bladder			Back or neck pain		
Urinary incontinence					
Decreased sexual desire					
Pain with intercourse					
Sexually transmitted disease					
Fertility issues					

Initial as Reviewed by Provider: _____