

NKL NEUROLOGY PLC

NIDA K. LAURIN, M.D.

9817 North 95th Street, Suite 110 Scottsdale, AZ 85258

PH: 480-779-3997/ FX: 480-779-1305

www.nklneuro.com

Welcome to our office! We are sending you our patient information packet to be completed prior to coming in. There are several pages to be filled out and can take some time. You will need to bring the completed packet with you for your appointment. Upon arrival, please notify the front desk. The patient information packet, and co-pay, (if applicable) will be collected at that time. We will make a copy of your insurance card and photo ID at the same time. Please arrive 15 minutes prior to your appointment so we can prepare a chart and enter your information as a new patient.

For our patients that are part HMO or POS plans: you as the patient are responsible for obtaining the referrals for your initial office visit and ALL follow-up visits. If you do not have a referral at the time of your appointment, we will not deny you care, **but you will have to pay for the full office visit at the time of service. We will not make any exceptions.**

We collect all co-pays, coinsurance and deductibles before your appointment. We accept cash (exact amount), check, Visa or Master Card.

We ask that our patients **REQUEST** all recent lab work, tests, X-rays, CT or MRI reports and films from the referring physician before your New Patient Consultation. You will be asked to keep you films and take them with you at the end of your appointment; we do not keep patients' films. They are the property of the patient and should be kept with them at all times. You may have your referring physician or primary care physician fax any reports to (480) 779-1305.

INSURANCE: All major insurance (our website has most recent accepted insurance list) and Medicare are accepted, but please call our office to make sure that we are participating providers with you insurance.

APPOINTMENTS: Appointments are scheduled by calling the receptionist during office hours at (480) 779-3997. We do our best to stay on schedule, though at times, emergencies do arise.

CANCELLATIONS: Please call to notify us at least 24 hours in advance if you cannot keep your appointment. If you are going to be late and we are notified in time, we will provide you with all available options for being seen or rescheduled. We know how valuable your time is and ask for the same consideration to our office. Chronically late or missed appointments without advance notice will incur a cancellation fee or discharge from our clinic. If you do not cancel a scheduled appoint, on the third missed appointment, you may be discharged from the practice and also charged \$50.00 for every no show appointment.

PRESCRIPTIONS: All new prescriptions will require an office visit. Please monitor the amount of medication you have on hand and have your pharmacy fax our office at (480) 779-1305 with refill requests rather than calling the office directly. Please allow a minimum of 2 working days for processing your refill. NO prescriptions or refills will be filled after hours or on weekends.

EMERGENCIES: If you are truly experiencing an emergency, please call 911 immediately. If it is urgent, have someone take you to any urgent care or emergency facility.

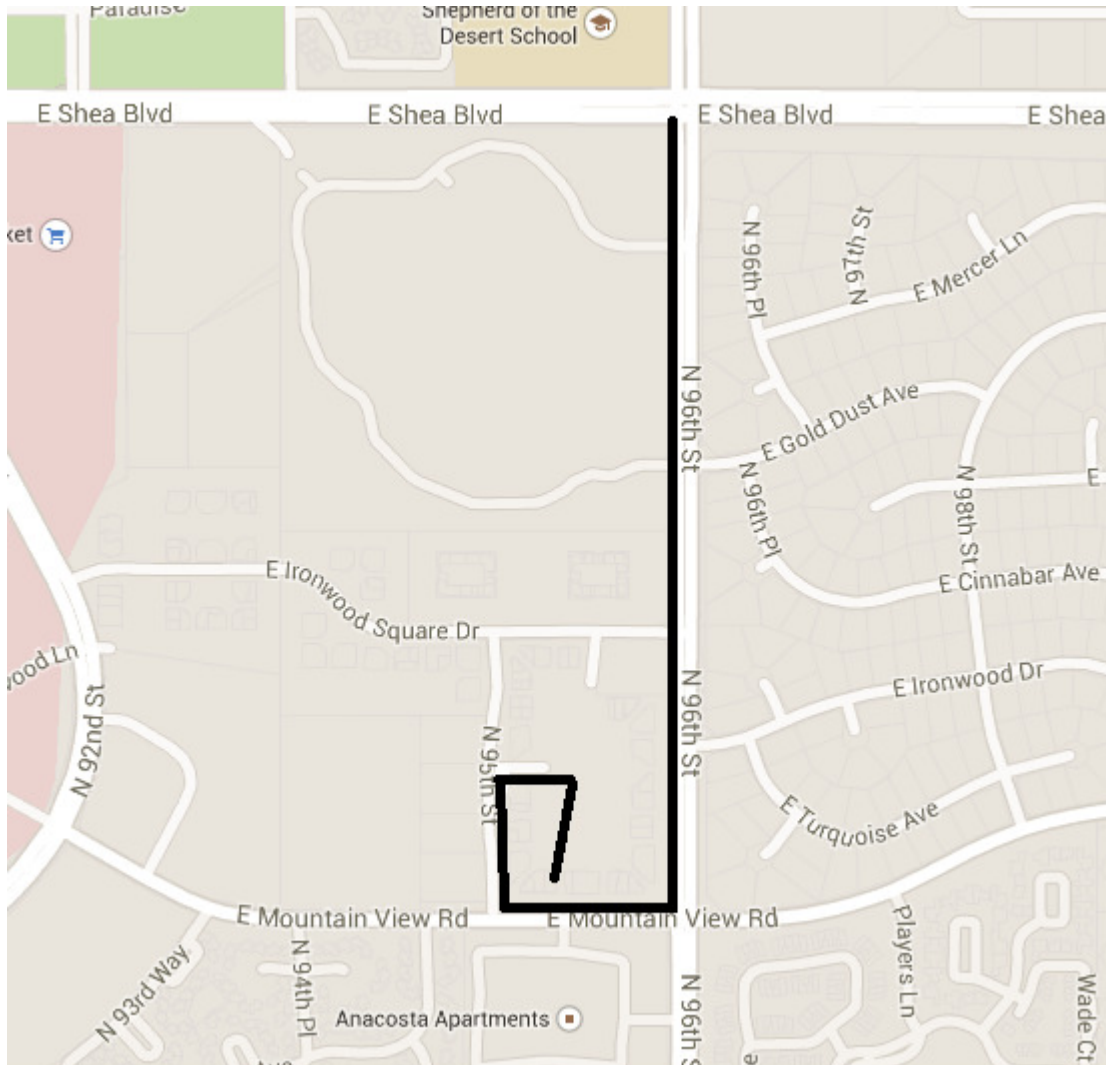
TEST RESULTS: After completing scheduled test or lab work, please call our office and schedule a follow up appointment to review results.

MEDICAL RECORDS: A signed medical records request form is required prior to copying/mailling/faxing any records. Medical records are provided via a records coping service which can take up to 30 days for routine requests.

OFFICE HOURS: 8:00am -4:30pm, Monday-Friday

DIRECTIONS: Our new office is located in the IRONWOOD SQUARE OFFICE COMPLEX, on the West side of 96th Street. Exit the 101 loop at Shea Blvd. Drive East to 96th Street and turn right, going South on 96th Street. The first street South of Shea Blvd. (third right) is IRONWOOD SQUARE DRIVE, turn right, then make an immediate left on 95TH Way into the parking lot. Our office is located at the south end of the parking lot, towards the right hand corner.

9817 N 95th St, Suite 110
Scottsdale, AZ 85258
(480) 779-3997



DIRECTIONS:

Our office is located in the IRONWOOD SQUARE OFFICE COMPLEX, on the West side of 96th Street. Exit the 101 loop at Shea Blvd. Drive East to 96th Street and turn right on 96th Street. Continue on 96th Street to the next light which is Mountain View. Make a right at Mountain View, then make the first right on 95th Street. Make the first right into our parking lot. At the stop sign, make a right & drive straight ahead to our office. Park and come around to the left. Our office faces the East, Suite 110. NKL Neurology is on the front door, along with Dr. Nida Laurin's name

NKL Neurology Financial Policies

(Rev. M-3.2-11 10-01-2013)

Insurance coverage: We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If we are a participating provider with your plan, but do not have an up-to-date insurance information or we are not notified about insurance changes (at least 48 hr prior to the appointment), payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits and rules is your responsibility.** Please contact your insurance plan with any questions you may have regarding your coverage.

Insurance Referrals / Authorizations: Your insurance may require a referral form from your primary care physician for procedure/service(s) prior to your visit. NKL Neurology attempts to obtain appropriate insurance referrals prior to the office visit or procedure. However, it is the patient's responsibility to verify that these referrals/authorizations are in place before services/tests are performed. All patients should be aware that if services or tests are performed without proper authorization, they are financially responsible for the entire bill. If you are unable to produce a referral at the time of your visit, you will be given the option to reschedule the visit or sign a waiver of insurance and pay for the visit in full. With most insurance carriers, an authorization or referral does not guarantee services will be covered

Insurance deductibles, coinsurance co-payments and insurance not covered services: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Deductibles are due at the time of notification by your insurance company. Such notification may be a verbal notice at the time of insurance verification, an Explanation of Benefits from your insurance company or a statement from NKL Neurology. Any co-pay not received at the time of service will result in a \$10 processing fee. If co-pay is received within 7 days of the date of service, the \$10 processing fee can be waived. Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service. Any outstanding balance after 30 days, but not exceeding 60 days may incur a \$10 monthly statement processing fee, in addition to the initial balance.

Insurance billing: We will bill you insurance for services rendered in our office as a courtesy to our patients, but we reserve the right to cancel these services at any time. We are required to file with your primary insurance carrier only. It is your responsibility to file charges with any secondary insurance carriers for reimbursement. Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.

Missed or cancelled appointments: Our policy is to charge for missed appointments not canceled within 24 hr prior to your appointment. A \$25.00 (15 min appointment), \$50.00 (30 min appointment) and \$80.00 (60 min appointment) fee for cancellation is required to reschedule if you do not keep your scheduled appointment or fail to cancel in a timely manner. If you are more than 10 minutes late for an appointment, you will be marked as a No Show. Weekends and holidays do not count in the 24 hours (ie. calling Saturday or Sunday to cancel a Monday morning appointment results in a charge. Monday appointments need to be cancelled by Friday to avoid a charge).

HSA & High Deductible Insurance Plan Patients: Patients enrolled in these types of plans are responsible for the payment of the deductible for treatment and services received. Estimated deposit is required on the day of the visit. The deposit will be applied to whatever patient balance is not paid by your health insurance plan (such as deductibles, co-insurances, co-pays and/or non-covered services).

No Insurance Coverage: For patients with no insurance coverage, NKL Neurology requires a deposit for both new and return patients. New patients are required to make a \$250.00 (it will cover new patient consult only) deposit prior to scheduling an appointment. Return patients are required to make an \$80.00 (it will cover established patient consult only) deposit when they check-in for their appointments. Patients with no insurance should discuss fees and treatment prices prior to the appointment. Information is available at 480 779-3997.

46 **Payment Arrangements:** If you suddenly find yourself unable to pay a bill, we offer alternate payment
47 arrangements. All payment arrangements must be in writing. Additional fees may be charged to unpaid balance,
48 depending on the complexity of the payment arrangement.

49 **Auto Accidents and Personal Injuries (ie. lawsuits):** If your problem is due to an auto or other injury please let us
50 know immediately so that the correct insurance information can be generated for you. **Since your injuries may**
51 **involve different insurance companies with whom we are not providers, payments for medical care for auto**
52 **accidents or personal injury (lawsuit) in our office are due at the time services are rendered.** We will send in an
53 insurance claim for you, and your insurance company will reimburse you directly. We can provide you with copies
54 of reports and paperwork required for a minimal fee. We do not accept liens. We will suggest specialists or testing
55 based on medical necessity in our opinion. It is your responsibility to find the X-ray, lab, specialist, chiropractor,
56 acupuncturist or other specialist that will accept your insurance. Please call your insurance company, or the specialist
57 to whom we refer you, with any questions about coverage. If these policies are not acceptable to you, you will need
58 to find a different doctor for your auto accident or personal injury claim, though we can still see you for your other
59 regular medical needs.

60
61 **Additional paperwork (disability, FMLA, insurance, etc):** Any paperwork needed to be filled out by the
62 physician will result in a \$10.00 (single sided page) fee per page per side. Depending on the length of the paperwork
63 and complexity fees will be assessed on case by case basis. A 48 hour notice is required for all paperwork.
64

65 **Nonpayment/delinquent accounts:** If the patient responsibility portion of your account is over 60 days past due,
66 you will receive a letter stating that you have 10 days to pay your account in full to halt collection activity. In the
67 event your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing and
68 processing costs. Patients with unpaid delinquent accounts or accounts which have been sent to collections may be
69 discharged from our practice.

70 **Credit/Debit Cards:** NKL Neurology accepts VISA or, MasterCard in the office and over the phone.

71 **Personal Checks:** Checks must be from an Arizona bank, have an imprinted name and physical in-state address (no
72 post office boxes) of the customer. Checks can be made payable to NKL Neurology with a returned check fee of
73 \$35.00 per returned item. Payments on returned checks (check total, returned check fees, and related fees) must be
74 paid by cash or money order or certified check. There will be no exceptions to this policy. Returned checks that are
75 not paid in full will be turned over to the State's Attorney's Office.

76 By signing below, the undersigned acknowledges that the above NKL Neurology Financial Policies have been read
77 and understood.

78 Patient Name (please print) _____

79 Patient Signature _____

80 Date ____ / ____ / 20____

81 _____

82 Parent/ Legal Guardian Name (please print) _____

83 Relation _____

84 Signature _____

HIPAA NOTICE OF PRIVACY PRACTICES

NKL NEUROLOGY
Nida K. Laurin, MD
Scottsdale, AZ 85258
480-779-3997 (p)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control over your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information : Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your health information, as necessary, to a home health agency that provides care to you. For example, your protected information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may also use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law - Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements.

Legal Proceedings - Law enforcement: Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization

or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payments or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made. if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14. 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:
Print Name _____

Signature _____ Date _____

PATIENT INFORMATION

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other _____

Social Security Number _____ - _____ - _____ ☐ Female ☐ Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Work _____ ☐ Day ☐ Evening Home _____ ☐ Day ☐ Evening
Cellular _____ Pager _____

Address _____

City, State, ZIP (+4) _____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Emergency Contact Relationship to Patient _____

Referring Physician Name _____

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____ - _____ - _____ ☐ Female ☐ Male Date of Birth _____ / _____ / _____

E-Mail Address _____

Phone Numbers Work _____ ☐ Day ☐ Evening Home _____ ☐ Day ☐ Evening

Address _____

City, State, ZIP (+4) _____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

Name of Insured _____ Patient Relationship to Insured _____

Insured Employer Name _____

Insurance Company/Phone Number _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Insured Date of Birth ____/____/____ Insured's Social Security Number ____-____-____

Insurance Company Address _____

Name of Insured _____ Patient Relationship to Insured _____

Insured Employer Name _____

Insurance Company/Phone Number _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Insured Date of Birth ____/____/____ Insured's Social Security Number ____-____-____

Insurance Company Address _____

Patient (or Responsible Party) Signature _____ **Date** _____

PATIENT HISTORY

NAME _____ AGE _____
LAST FIRST

Main complaint and symptoms (describe what and where it hurts): _____

When did this problem first start? _____ Date _____

Was this due to an accident? No _____ Yes _____ LEGAL CASE pending? Yes _____ No _____

Describe frequency and duration of symptoms: _____

Have you consulted other doctors? No _____ Yes _____ If yes, whom? _____

PAST AND PRESENT HISTORY: (illness such as high blood pressure, diabetes, etc.)

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

OPERATIONS: please list all, even minor ones, such as tonsillectomy.

Operations (s)	Date	Hospital
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Any other hospitalizations, tests, injuries? No _____ Yes _____ If yes, please describe what and when:

Allergies to medications, please list:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Food Allergies:

1) _____ 3) _____
2) _____ 4) _____

FAMILY HISTORY

Please indicate if any blood relative(s) have had:

<u>PROBLEM</u>	<u>WHICH RELATIVE</u>	<u>PROBLEM</u>	<u>WHICH RELATIVE</u>
Diabetes	_____	Parkinsons Disease	_____
Epilepsy/Seizures	_____	Multiple Sclerosis	_____
High Blood Pressure	_____	Migraines/Headaches	_____
Cardiac Disease	_____	Dementia	_____
Stroke	_____	Blood Clots	_____
Aneurysm (Brain / Aortic)	_____	Mental Illness	_____
Osteoarthritis/Rheumatoid Arthritis	_____	Cancer (what kind)	_____
Other	_____	Cancer (what kind)	_____

PLEASE LIST FAMILY MEMBERS LIVING, WELL AND/OR DECEASED AND CAUSE OF DEATH

<u>Family Member</u>	<u>Age</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____
Mother	_____	_____
Brother(s)	_____	_____
Sister(s)	_____	_____
Son(s)	_____	_____
Daughter(s)	_____	_____

PERSONAL AND SOCIAL HISTORY

Are you presently working? Yes _____ No _____ Occupation _____

a) If disabled, date disability began: _____

Do you smoke? No _____ Yes _____ How much _____

If you smoked in the past:

When did you quit? _____ How many years did you smoke? _____ How many per day _____

Do you drink alcohol? Yes _____ No _____ How often? _____ How much? _____

Do you drink caffeine? Yes _____ No _____ How often? _____ How much? _____

NKL NEUROLOGY

POLICY ON NARCOTIC PAIN MEDICATIONS

Dear Patient:

It has come to our attention that many of our patients are unclear on our policy in prescribing narcotic pain medications (also known as Class III drugs).

NKL Neurology is not in the practice of long term pain management. Therefore, should pain related medications be required, **a one time, 3 months (90 day) prescription** will be issued. We feel that with alternative treatments and/or physical therapy there should be marked improvement at the end of the 3 month period and that no further pain medication should be necessary. If at the end of the 3 month period further pain management medications are needed, you will be referred to your primary care physician for additional medication refills, or we can refer you to a pain management program or specialist.

Furthermore, it has been a longstanding policy that **NO** medication refills will be done after hours, on Fridays afternoons, or over the weekends. Please plan ahead and contact your pharmacist before the time that your prescription(s) run out. Also, pain medications will not be phoned in but will be in **written form only**, the patient will be **required to pick up** the prescription(s) from the office and be seen in a follow up appointment.

Should you have any questions in this matter, please feel free to discuss it with your physician at the time of your appointment.

Sincerely,

NKL Neurology

Patient Signature

Date

NKL NEUROLOGY PLC

PATIENT COMMUNICATIONS SHEET

PATIENT NAME: _____

DATE: _____

THE FOLLOWING INSTRUCTIONS PERTAIN TO THE ABOVE NAMES PATIENT:

OK TO CALL HOME AND LEAVE MESSAGES

DO NOT CALL HOME PHONE

DO NOT CALL WORK NUMBER

CALL WORK NUMBER ONLY

PERMISSION TO SPEAK WITH FAMILY MEMBERS

IF PERMISSION GIVEN TO SPEAK TO FAMILY MEMBERS/FRIENDS, ONLY
SPEAK TO FAMILY MEMBERS/FRIENDS LISTED BELOW:

PATIENT MEDICATION LIST

<u>PATIENT NAME</u>		<u>DATE OF BIRTH</u>		
<u>PHARMACY NAME</u>		<u>PHARMACY PHONE AND FAX NUMBER</u>		
<u>MEDICATION ALLERGY (NAME OF MEDICATION)</u>		<u>REACTION TO MEDICATION</u>		
<u>CURRENT MEDICATIONS</u>				
<u>NAME OF MEDICATION</u>	<u>DOSAGE (MG/MCG)</u>	<u>QTY TAKEN DAILY</u>	<u>START DATE</u>	<u>END DATE</u>
<u>PATIENTS SIGNATURE</u>		<u>DATE REVIEWED BY PATIENT</u>		
<u>PATIENTS SIGNATURE</u>		<u>DATE REVIEWED BY PATIENT</u>		
<u>PATIENTS SIGNATURE</u>		<u>DATE REVIEWED BY PATIENT</u>		
<u>PATIENTS SIGNATURE</u>		<u>DATE REVIEWED BY PATIENT</u>		

Please list over the counter medication, vitamins, supplements and etc.

NKL NEUROLOGY PLC

PATIENT'S NAME: _____

DATE: _____

REVIEW OF SYSTEMS

PLEASE LET US KNOW IF YOU HAVE **RECENTLY** EXPERIENCED ANY OF THESE SYMPTOMS

PLEASE MARK AN (X) IN THE SPACE PROVIDED. PLEASE CIRCLE WHERE APPROPRIATE

MUSCULOSKELETAL		EAR, NOSE, THROAT, MOUTH		GASTROINTESTINAL	
Joint pain		Toothache		Indigestion	
Muscle pain		Jaw pain		Nausea	
Arm weakness		Ear pain		Vomiting after eating	
Arm/ hand/ finger pain		Ear discharge		Blood in vomit	
Arm numbness/ tingling		Ringin in ear- L / R		Abdominal pain	
Neck pain		Hearing loss		Jaundice	
Back pain		Nosebleeds		Change in bowel habit	
Leg/ foot pain		Nasal congestion		Heartburn	
Leg/ foot tingling		Sinus problems		GENITOURINARY	
Leg weakness		Inability to smell/ taste		Painful/ burning urination	
NEUROLOGICAL		Change in voice		Difficulty urinating	
Fainting spells		Difficulty swallowing /choking		Blood urine	
Seizures		Tongue numbness / pain		Inability to control urine	
Loss of memory		Mouth sores		Flank pain	
Dizziness		INTEGUMENTARY		RESPIRATORY	
Disorientation		Skin lesions		Snoring	
Headaches		Hair loss		Sore throat	
Difficulty with coordination		Oily / dry skin		Chronic cough	
Difficulty with speech		Breast pain / tenderness		Bloody sputum	
Inability to concentrate		Nipple discharge		Shortness of breath	
Blurred vision				HEMATOLOGIC/LYMPHATIC	
Face weakness L / R		ENDOCRINE		Swollen glands / nodes	
Face numbness L / R		Irregular periods		Bleeding tendencies	
Frequent tripping/ falls		Heavy bleeding		Bruising	
CARDIOVASCULAR		Hot flashes		ALLERGIC/IMMUNOLOGIC	
Chest pain		Excessive thirst		Rash/seasonal allergies	
Irregular pulse/ palpitations		Erectile dysfunction		PSYCHIATRIC	
Swelling in feet/ hands				Anxiety	
Leg pain while walking		EYES		Depression	
Shortness of breath with activit.		Double vision		Insomnia	
CONSTITUTIONAL		Eye injuries		Nightmares	
Fever / chills / night sweats		Dry eyes		Hallucinations	
Change in appetite ↑ or ↓		Excessive tearing		Moodiness	
Weight loss / gain		Droopy eyelids		Irritability	
Fatigue		Poor vision		Excessive sleepiness	

Please note any other health problems: _____

New Medications: _____

Patient Signature _____

Date _____