REGISTRATION FORM

Ventura County Urology Medical Group
(805) 653-1533
CEDRIC B. EMERY, M.D.

Name of Patient _____
Last Initial First

Address _____
Street City State Zip

Phone _____ Cell Phone _____ Date of Birth _____ Age _____

DL# _____ Soc. Sec. # _____ Marital Status _____ Sex _____

Occupation _____ Employer _____ Phone _____

Employer's Address _____
Street City State Zip

Primary Insurance Co. _____ I.D. # _____ Group # _____

Name of Insured _____ Date of Birth _____

Secondary Insurance Co. _____ I.D. # _____ Group # _____

Name of Insured _____ Date of Birth _____

Employer _____ Soc. Sec. # _____

Emergency Contact _____ Relationship to Patient _____

Address _____

Phone _____ Date of Birth _____ Soc. Sec. # _____

Employer _____ Phone _____

Referred by _____ Address _____

Family Physician _____ Address _____

Other Physician _____ Address _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPIDITE INSURANCE CARRIER PAYMENTS, HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____

I request that payment of authorized Medicare/Other Insurance company benefits be made to Ventura County Urology for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.
I authorize Ventura County Urology to release to Medicare or other insurance company any information needed for this or a related Medicare claim/other Insurance Company claim.
I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

PATIENT'S SIGNATURE _____ DATE _____

Ventura County Urology Medical Group

PATIENT CONSENT TO CREDIT CHARGES

I, _____, authorize **Ventura County Urology Medical Group, Inc.** to charge my credit card for the balance of charges not paid by my insurance company. I understand that **Ventura County Urology Medical Group, Inc.** will make TWO ATTEMPTS ONLY to notify me prior to my credit card transaction. At that time I will be given the opportunity to send a check, if I prefer. If I cannot be reached, then my credit card will be charged. I understand that it is my responsibility to make sure my daytime telephone numbers given to the office are correct.

I assign my insurance benefits to the provider listed above. I understand that this form is valid unless I cancel the authorization through written notice to the health care provider.

Cardholder Signature:_____Date:_____

Patient Name:_____

Cardholder Name, as appears on card:_____

Cardholder Address:_____

City: _____ State:_____ Zip:_____

O Visa O Mastercard O American Express O Discover O Debit Card

Credit Card Number:_____

3 digit or Amex 4- digit #: _____ Expiration Date:_____

Ventura County Urology Medical Group

CREDIT CARD ON FILE NOTICE

To all of our new and established patients:

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which we all expect to give, which is later used to pay the hotel or rental car bill.

We have implemented a similar policy. You will be asked to sign a credit card form at the time you check in. This information will be held securely until your insurance has paid their portion and notified us of the amount of your share of the claim. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge mailed to you. You will receive a call from our office letting you know that we are going to charge your credit card and the amount to be charged. At that time, you will be given the opportunity to send us a check, if you prefer, for your balance due. You should have also received an explanation of medical benefits from your insurance company and should already be aware there is apportion of the fee that is your responsibility, so the charge will not come as a surprise to you.

This will be an advantage to you, if you do prefer not to mail us checks. It will be an advantage to us as well since it will greatly reduce the number of statements that we have to generate and send out. The combination will benefit everyone in helping to keep the cost of healthcare down.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment

Co-pays, coinsurance and any deductible due at the time of your visit will, of course, still be due at the time of visit, before you see the Doctor, Physician's Assistant or other medical professional.

As a consumer of a product, healthcare is like any other; you are purchasing an "item;" in this case, healthcare, and as with any other consumer purchase, you would expect to pay at the time you purchase the service or merchandise.

Thank you for your cooperation and understanding regarding our new office policy. If you have any questions about this payment method, do not hesitate to ask us.

Sincerely,

Cedric B. Emery, M.D.

Ventura County Urology Medical Group

FINANCIAL POLICY

All patient responsibility amounts, including Deductibles, Co-Payments and Patient Percentages are due at the time of service. This also includes any amounts due prior to surgery. A credit card form will be kept on all patients.

We will bill your insurance company for you whether by contractual agreement or by courtesy for services rendered. If we should bill for a service to an Insurance Company that we are not contracted with and the payment goes to you, then we do expect that your payment be sent to us immediately upon receiving your insurance payment. If your payment is not sent to us. then your credit card on file will be billed. (If the patient overpays, a full refund will be issued to them.)

Patients covered by Medicare only will be expected to pay their 20% portion at the time of their appointment or we can use their credit card on file. Medicare's 2016 deductible is $166.00 which will need to be met before Medicare will pay your claims.

This office accepts payments in the form of Cash, MasterCard, Visa, American Express, Discover, Debit cards and checks. There will be a $40.00 charge on all returned checks.

We will do our best to call and check on your eligibility and benefits, but ultimately, it is the responsibility of the patient to understand their own eligibility and benefits at the time of service. PLEASE KNOW AND UNDERSTAND YOUR INSURANCE.

We ask that if we do have to send you a statement, that you pay your balance on that first statement. There will be a monthly $5.00 re-bill charge on all balances that need to be billed again. (Unless a payment arrangement has been made.) There is also a 1.5% interest rate on all patient account balances past 30 days. If your account should fall delinquent and have to be sent to our collection agency, there is a 40% collection fee added. This amount is the fee the collection agency charges us, and we feel that this should be the responsibility of the patient, not the Physician. Thank you for your cooperation and understanding.

I have read, understand and agree to abide by the Financial and Credit Card Policies for Ventura County Urology Medical Group.

Patient/Insured (Printed Name):_____

Patient/Insured (Printed Name):_____Date:_____

Ventura County Urology Medical Group

ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to the office of Ventura County Urology for any charges not covered by my health care benefits. It is my responsibility to notify the office of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the actual claim. I realize that I am fully responsible for any claim or portion of claim that is not paid. I understand that by signing this form, I am accepting financial responsibility, as explained above, for all payments due for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare/if I am a Medicare beneficiary, *to* Ventura County Urology Medical Group for all covered medical services and/or supplies provided to me during all courses of my treatment and care. I understand and agree that this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Ventura County Urology Medical Group and will constitute a continuing authorization, maintained on file at this office, which will authorize and allow for direct payment to Ventura County Urology Medical Group of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by Ventura County Urology Medical Group.

Authorization to Release Information

I authorize the release of my medical or any other information to the Center for Medicare Service, my insurance carriers or other entity necessary to determine insurance benefits payable for related medical services and/or supplies provided to me by Ventura County Urology Medical Group. A copy of this authorization will be sent to Center for Medicare Service, my insurance carrier, or other medical entity, if requested. The original authorization will be kept on file by the office of Ventura County Urology Medical Group.

Patient/Insured (Printed Name):_____

Patient/Insured (Printed Name):_____Date:_____

Ventura County Urology Medical Group

NOTICE OF PRIVACY PRACTICES

- This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- At Ventura County Urology, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another physician we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may call to confirm your appointments. If you are not at home, we may leave this information on your answering machine or with the person who answers the phone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We will include your statement in your file. If we agree to an amendment, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint regarding your personal health information with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Lynn Schettler, at (805) 653-1533.
- This notice goes into effect as of April 14,2003.

ACKNOWLEDGEMENT

I have received a copy of Ventura County Urology Medical Group Notice of Privacy Practices

Patient/Insured (Printed Name):_____ Date:_____

If signing as a parent or guardian, please note name of patient:_____

NAME _____ DATE _____

Have you **seen** blood **in the urine?** _____None _____ Yes _____ No _____In Urinalysis only

If yes, what color was the urine? (bright red, pink, et cetera) _____

When was blood first seen in the urine? _____ . _____

Did you see clots? _____Yes _____**No** If yes, were the clots stringy?_____ Yes _____No

Do you smoke? _____ Yes _____No # of packs a day? _____ If you quit, how many years did you smoke?_____

Have you had exposure to chemicals or second-hand smoke?_____

How many times do you urinate during the day?_____

How many times do you urinate at nighttime?_____

How would you describe your urinary stream? (Circle all that apply)

Weak Stop-Start Dribbles Split Spraying Hesitation to start I Cannot Urinate

Does the bladder feel empty after urinating? _____ Yes _____ No

Do you have pain? _____ Yes _____ No If yes, where is the pain?_____

When did the pain begin? _____

Have you had a Urinary Tract Infection in the past? _____Yes _____ No _____Not Sure

If yes, did you also have a fever at that time? _____ Yes_____ No _____ Not Sure

If you are male, have you had Prostatitis in the past? _____ Yes _____ No _____Not Sure

If yes, were you treated with antibiotics? _____ Yes _____ No _____Not Sure

Do you now have fever? _____ Yes_____No _____ Not Sure

Have you ever had a kidney or ureteral stone? _____ Yes _____ No If yes, how were you treated *&* when?

Are you leaking urine? _____ Yes ____ No (If yes, check all that apply)

____when standing from a sitting position ____ only with exertion, stress or straining _____ when leaving the house

____when I have the urge to void and am rushing to the bathroom _____ when the weather is cold ____all the time

When did incontinence begin?_____

How bothersome is this to you?_____

How many pads do you wear during the day? _____ How many pads at night? _____

Have you ever had a stroke or TIA? _____ Yes _____No _____Not Sure

Are you having trouble maintaining erections? Yes_____No _____On occasion If yes, when did this begin?

Are you having trouble achieving erections?_ Yes_____No _____On occasion If yes, when did this begin?

If you answered "yes" to either of the last two questions, check all that apply: _____I am under a lot of emotional stress

____The penis has a bend and is painful when erect _____I have Diabetes _____I have no or **low** desire for **sex**

___ The penis has a bend and is not painful when erect ____I have a history of trauma to the penis/scrotum

Have you tried any of the following: Levitra, Cialis, Viagra, Staxyn, Tribulus, Tri-mix injection, Muse, Vacuum erection device

or other method? _____Yes _____No Which ones did you try? Describe the response: _____

Have you had your Hormone levels recently checked by a doctor? _____ Yes _____ No (If yes, please provide those labs).

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and provide the date of surgery:

Cardiovascular
Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General
Brain Surgery
Laminectomy Lymphatic
Node Dissection
Parathyroidectomy
Pilonidal Cyst Incision Skin
Grafting

GI
Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy
Colon Resection
EGD
EGD/Dilation Esophagus
Fissurectomy
Gastric Surgery
Hemorrhoidectomy
Ileostomy
Laparoscopy Liver
Surgery Liver Transplant
Lumpectomy of Breast
Lysis Adhesions Nissen
Fundoplication
Splenectomy Stomach
Surgery Umbilical
Hernia Ventral Hernia
Repair

GU
Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Figuration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelectomy
Ileal conduit
Indigo Laser Surgery
Inguinal Herniorrhaphy
Interstim
Kidney Stone
Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatocelectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy
VLAP

HEENT
Cataract Surgery
Corneal Surgery
Ear Surgery Eye
Surgery Facial
Surgery Mastoid
Surgery Nasal
Surgery PEG
PE Tubes Septoplasty
Sinus Surgery Tonsil
Surgery Thyroid Surgery
TMJ Surgery

Musculoskeletal
Amputation
Arthroscopic Knee

Surgery
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Surgery
Knee Surgery
Leg Surgery
Rotator Cuff Surgery
ShoulderSurgery

Respiratory
Lung Surgery

Skin
Basal Cell Carcinoma
Melanoma Squamous
Cell Carcinoma

Other:_____

FAMILY HISTORY

Please CIRCLE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

Arthritis _____
Bed wetting _____
Bladder Cancer _____
Cancer (site unknown)_____
Crohn's Disease _____
Depression _____
Diabetes _____
Gout _____
Heart Attack _____
Hypertension _____
Kidney Cancer_____
Kidney Disease _____
Leukemia _____
Malignant Melanoma
Multiple Sclerosis_____
Laryngeal Cancer_____
Pancreatic Cancer_____
Prostate Cancer Stroke_____
Thyroid Disease_____
Tuberculosis_____

Other: _____

Name:_____ **Date:**_____

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular
Anemia
Angina
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhythmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

Endocrine/Metabolic
Diabetes Mellitus, non-insulin dependent Diabetes Mellitus, insulin dependent Diabetes Mellitus, uncontrolled Goiter Gout
Hyperthyroidism
Hypothyroidism

General
Allergies Electrical Injury
Exposure to Chemicals
Hepatitis A Hepatitis B
Hepatitis C
Hypercholesterolemia
Hyperlipidemia
Infectious Disease
Lipid Disorder
Malaise
Obesity
Paget's Disease
PCKD
PCO
Raynaud's Syndrome
Sleep Apnea

Gi
Cholecystitis
Cholelithiasis
Chronic Liver Disease
Colitis
Constipation
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
GERD
Hemorrhoids
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease/Failure
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis

GU
AIDS
Bladder Outlet Obstruction Bladder Stone Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency Chronic Renal Failure Crossed Fused Ectopia Hematuria
Impotence of Organic Origin
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer Kidney Disease Kidney Infection
Kidney Stones Libido Decreased
Nephrolithiasis Nephrotic Syndrome Neurogenic Bladder Orchitis
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure Recurrent UTI
Renal Cell Cancer Renal Failure Renal Insufficiency Testicular Cancer Transplant Recipient Transitional Cell CA Bladder
Transitional Celi CA Ureter
Undescended Testicle (Birth)
Urinary Tract Infection
Venereal Disease

GYN/OB
Breast Cancer Breast Disease Endometriosis
Menopause Menstrual Problems Osteoporosis
Ovarian Cancer Uterine Fibroids

HEENT
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Menniere's
Mumps
Sinusitis
Tinnitis
Vertigo

Musculoskeletal
Arthritis
Back Pain
Carpal Tunnel Syndrome
Claudication
Fibromyalgia
Mortons Neuroma

Neuroloaical/Psvcholo gical
ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory
Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis

Tumors
Brain Cell Carcinoma Brain Tumor Breast Cancer
Cervical Cancer Colon Cancer Fibrocystic Breast Disease Gastric Cancer
Laryngeal Cancer Lung Cancer Lymphoma
Melanoma Ovarian Cancer
Pancreatic Cancer Rectal Cancer Rectal Cancer
Rectal *Cell* Cancer
Sarcoidosis Testicular Cancer Transitional Cell CA Bladder
Transitional Cell CA Ureter
Uterine CA

Other:_____

Tobacco per day:

___None _____Yes # _____ Packs/day_____ Cigarettes/day ___ Smokeless Tobacco

If you previously stopped, when?_____ __±_____

Recreational Drugs: ___ None If yes, please list: _____

Caffeinated beverages: None Low Moderate Excessive

Recent Foreign Travel: None Americas___.'_____ World-wide _____

REVIEW OF SYSTEMS: (CIRCLE all symptoms that you now have.)

Constitutional
Appetite Changes
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Swollen Glands
Weight Gain
Weight Loss

Eves
Blind
Blurred Vision
Double Vision
Glaucoma
Worsening Eyesight

Alleraic/Immunologic
Animal Allergies
Drug Allergies
Environmental Allergies Food Allergies Seasonal Allergies

Neurological
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors

Endocrine
Diabetes Excessive thirst Pituitary Disease
Thyroid Disease
Tired/Sluggish Too Hot/Cold

Gastrointestinal
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Hemorrhoids
Indigestion/heartburn
Nausea/vomiting
Rectal Bleeding

Cardiovascular
Chest Pain/Angina
Shortness of Breath
Edema Heart Attack
Heart Failure Heart Murmur High Blood Pressure Irregular Heart Beat Atrial fibrillation Mitral Valve Prolapse Orthopnea
Pain/Cramps
Hips/Legs w/exercise
Palpitations
Skipped Heart Beats
Swelling

Musculoskeletal
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

Ear/Nose/Throat
Ear Infection
Sinus Problem
Sore Throat

Genitourinary
Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Painful Ejaculation
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections Urine retention Urologic Cancer Urologic Surgery Vaginal Bleeding Vaginal Discharge/Problems
Weak Stream

Respiratory
Asthma
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of breath
Tuberculosis
Wheezing

Hematological/Lymphatic
Swollen Glands Blood clotting problem
Bleeding Problem
Hepatitis HIV (AIDS)
Sickle Cell

Psychological
Anxiety
Depressed
Generally satisfied with life

Other:_____

VENTURA COUNTY UROLOGY MEDICAL GROUP
2807 LOMA VISTA ROAD STE 101
VENTURA, CALIFORNIA 93003
PHONE: 805 653-1533 / FAX: 805 653-1530
CEDRIC B. EMERY, MD.

Name:_____ Date: _____

Referring Doctor: _____Family Doctor:_____

By what method did you choose our practice?

___Referring Physician_____ Friend____Yellow Pages ___Insurance Company _ Other

Why are you seeing the doctor today?_____

How long have you had this problem? _____

What improves or worsens the problem/pain?_____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain /symptom (sharp/dull, constant/intermittent, et cetera)_____

_____

Have you tried any medicine/treatment for this problem/pain?_____

CURRENT MEDICATIONS - Please list ALL medications you are currently taking including over the counter.

Drug Name(s):_____

Strength:_____

Directions/How you take it:_____

Attach list if necessary:

Pharmacy Name:_____Phone #::_____

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods):

_____

_____

SOCIAL HISTORY

Marital Status: Please indicate years

___ Single ___ Married____Separated___ Divorced __ Widowed __ Life Partner __Common Law

Spouse:_____ __

Dependants: Please indicate # of each, if you have:

__ Sons ___ Daughters___ Stepchildren ___ Adopted _ __Foster ___ Parents ____Grandparents

Occupation: Please circle one:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time,

Retired, Other:_____

Alcohol Consumption:

__ None __ Yes Occasional/Social___ # of drinks per day ___