Barbara L. Schwartz, MD, PA

		Appt Date:	Appt Time:
Last Name: To		Social Security No::	
First Name:	Mid. Initial:	Date of Birth:	
Home Address:		Age:	Sex:
Home Address2:		Home Phone:	
City, State, Zip: ,		Cell Phone:	
Patient Email Address:			
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally separated ☐Unknown			
Race: ☐Caucasian ☐Hispanic ☐Black / African American ☐Asian ☐Native American ☐Other Race ☐More than 1 Race			
Ethnicity: ☐Latino/Hispanic ☐Other ☐Not Reported/Refused ☐English ☐American			
Language: ☐English ☐Latin ☐Other – Please list:			
Referred by:		Referring Tel:	

PATIENT EMPLOYER	
Name:	Work Tel:
EMGERGENCY CONTACT	**PHARMACY INFORMATION:**
Name:	**Pharmacy Name:**
Contact Tel:	**Pharmacy Tel:**

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING PERSON(S):

Please list who you would authorize the release of medical information to:

Name:	Relationship:	Tel:
Name:	Relationship:	Tel:

PRIMARY INSURANCE	
Plan Name:	Group #:
Plan Tel:	Subscriber DOB:
Subscriber Name:	Subscriber ID/Policy #:
Relationship to Patient: ☐Self ☐Wife ☐Husband ☐Parent ☐Other	
SECONDARY INSURANCE	
Plan Name:	Group No.:
Plan Tel:	Subscriber DOB:
Subscriber Name:	Subscriber ID/Policy No:
Relationship to Patient: ☐Self ☐Wife ☐Husband ☐Parent ☐Other	

Assignment of Insurance Benefits

I authorize payment of medical benefits to: Barbara L. Schwartz, MD, PA for services rendered. I also authorize the release of any medical information necessary to process my insurance claims. I request and authorize that payment/insurance benefits be made directly to Barbara L. Schwartz, MD, PA any services furnished to the above named patient by Barbara L. Schwartz, MD, PA The signature below shall suffice for all insurance forms on a continuing basis. I understand I can change the authorization information anytime in writing.

Patient or authorized persons signature: _____ Date:_____

BARBARA SCHWARTZ, M.D.
PRACTICE LIMITED TO INTERNAL MEDICINE

Review of Systems (ROS)

Name:_____

Since your last exam, have you had the following:

CIRCLE IF YES

Date:_____

Loss of Vision, or Hearing, or Headache

Chronic Cough or Hoarseness

Shortness of Breath

Chest Pain with Activity or Stress

Rapid or Skipped Heart Beat

Fatigue

Weight Loss without Dieting, Loss of Appetite

Indigestion, Abdominal Pain, Nausea, Vomiting, Gas

Arthritis, Joint Pain, Low Back Pain, Muscle Cramps

Black Stools, Bright Red Blood from Rectum

Changes in Bowels, Family History of Polyps, Colon Cancer

Burning on Urination, Blood in Urine, Painful Urination

Getting Up at Night to Urinate, Family History of Prostate Cancer

Lumps or Bumps anywhere, Skin Cancer, Skin Rash

Numbness or Weakness, Swelling Feet or Ankles

Memory Loss

Sexual Dysfunction

Pain in Muscles of Legs when Walking

Do You Use Tobacco

Do You Drink Alcohol

Do You Exercise

Other Comments: _____

_____

_____

483 North Semoran Blvd. • Suite 200 • Winter Park, FL 32792 • Phone (407) 644-3866 • Fax (407) 644-2820

Fall Prevention Balance and Dizziness Survey

Patient Name: _____ **Age:** _____ **Date:** _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer.	Yes or Often	Some-times	No or Never
1. Do you ever lose your balance or feel dizzy or unsteady?			
2. Have you continued to experience dizziness after an injury or accident?			
3. Do you feel unsteady when you are walking or climbing stairs?			
4. Do you feel dizzy while sitting down or rising from a seated or lying position?			
5. Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?			
6. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
7. Are you dizzy or unsteady when you first get up in the morning?			
8. Do you ever fall or feel like you are about to fall for no apparent reason?			
9. Do you use a walker, cane, or any other form of assistance for your mobility?			
10. Have you had a recent loss of, or decrease in, your vision or hearing?			
11. Do you fear falling?			
12. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
13. Has your balance problem caused problems in your social life?			
14. Have you fallen more than once in the past year without an obvious cause?			
15. Does dizziness or imbalance interfere with your job or your household responsibilities?			

Please fill out the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

_____ Patient Signature

_____ Phone

Patient Name _____ Date _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

BARBARA L. SCHWARTZ, M.D., P.A.
483 NORTH SEMORAN BLVD. • SUITE #200 • WINTER PARK, FL 32792
Phone 407-644-3866 • Fax 407-644-2820

ACKNOWLEDGMENT OF POLICY REGARDING FOLLOW-UP VISITS

1. I, _____, acknowledge that any visit with Dr. Schwartz may involve various laboratory tests the results of which may not be available by the end of the visit.

2. I further acknowledge that obtaining the results of these laboratory tests may be important to assist Dr. Schwartz with providing me with the best medical advice possible under the particular circumstances.

3. I further acknowledge that, for patient privacy reasons, Dr. Schwartz will only discuss test results in-person during a follow-up visit with her. Dr. Schwartz will not discuss tests results over the telephone or via other means of telecommunication.

4. I, therefore, promise that I will make any and all necessary follow-up appointments with Dr. Schwartz at the end of each visit to obtain and discuss test results.

5. I acknowledge and agree that it is my responsibility to make and then keep (or reschedule as necessary) all follow-up appointments.

6. I have been advised of the risks and disadvantages of not making and/or not keeping all follow-up appointments and accept all such consequences. I unconditionally and expressly waive any and all claims and defenses that might be brought or asserted by me in any court or administrative action against Dr. Schwartz and/or Schwartz and Promes, PLC, in connection with or in any way related to my failure to make and then keep (or reschedule as necessary) all follow-up appointments.

7. I have had all of my questions fully answered to my satisfaction with respect to this Acknowledgment.

_____
(Printed Name of Patient)

_____
(Signature of Patient)

_____
Date

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: **Schwartz & Promes LLC Barbara L. Schwartz** Phone: **(407) 644-3866**

Address: **483 N. Semoran Blvd., #200, Winter Park, FL 32792** Fax: **(407) 644-2820**

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the earlier of: my death or the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

X _____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004

"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Withdrawal": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: *This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.*

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPAA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g ("FERPA"); 34 CFR parts 99 and 300; 42 CFR §59.11 (Family Planning); Florida Statute 408.051(4) ("Universal Patient Authorization Form"); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes §456.057(7)(a), §395.3025(4), §394.4615(2)(a), §381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).

OFFICE FINANCIAL POLICY

The last few years and the years to come are very busy with regard to health care reform. The insurance companies have initiated new changes that will affect the way we handle your account. These are some billing guidelines that our office follows that allow us to survive health care reform.

PLEASE READ THOROUGHLY AND SIGN THIS FORM

1. It is your responsibility to inform us of any changes regarding your Insurance or contact information. If you fail to do so, you will be responsible for any charges incurred.

2. We will collect your co-pay or any other uncovered expense at the time of service Please be prepared to pay before or after the doctor sees you.

3. Please be thorough with your insurance information if you expect us to file for you. You will be responsible for any unpaid balances due to lack of information.

4. It is at our discretion that we will charge your account with a re-billing fee if we must refile balances over 45 days old. This fee will be payable by you.

5. As a courtesy, we will file your insurance. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying, as they should.

6. Your insurance will send you an explanation of benefits (EOB) that explains what they have paid and a copy to our office. This is a record that you must keep on file. If you do not agree with the payment, please contact your insurance company.

7. If your insurance denies payment on your account, you will be asked to pay by check, cash, or credit card. If you do not pay in a timely fashion, your account will be subject to placement with a collection company.

8. TO ALL MEDICARE PATIENTS: We will continue to participate as a Medicare provider. We will bill Medicare as well as your secondary insurance, but if payment is not received from your secondary within 45 days, you will be notified and must pay our office the balance due. You must then contact your secondary insurance to refund you.

9. Patients requiring referrals due to your insurance plan must allow our office five (5) days to a quire this, please provide us with a fax # and any other information needed You must be seen at least once a year by our office to receive referrals.

10. SELF-PAY PATIENTS: This includes people with no insurance and patients who have an indemnity plan and wish to file their own insurance. Payments for medical service are expected on the day the service is rendered. If you are unable to pay for services in

(over)

full, you must contact our office to make a payment agreement before coming to see the doctor. If you have no agreement with our office, payment in full will be expected.

11. If your insurance is out of state (except for PPO insurance) or out of country coverage, you must pay for your visit at the time of service. Ninety-five percent of out of state insurance companies and a hundred percent of out of country companies pay the patient and will not pay us directly (even if they tell you that they will).

12. NO SHOW POLICY: In ordered to provide excellent patient care we reserve a scheduled appointment time especially for you. If you confirm your appointment and do not show or fail to give our office 24 hours notice of cancellation, your slot has been booked and cannot be overbooked for another patient. You will be charged a $30.00 no show fee.

13. RECORDS: There is a charge for records the fee is guided by the state, fees are .25cents per page up to 25 pages then a $1.00 a page after that no more that $35.00 plus postage if required.

14. FORMS: There is a fee payable in advance for all forms needing to be filled out by the doctor or forms requiring only a signature. This fee can range between $15.00 and $25.00.

AS A FINAL NOTE:

1. Our practice is not the cause of insurance delays or denials. We file to the Insurance companies on a timely basis.
2. Remember, you and /or your employer pay the monthly insurance premiums. Your insurance company is accountable to you, not us. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.
3. If you have any questions regarding this financial policy, please ask or call BEFORE you are seen

PATIENT
SIGNATURE:_____DATE_____
(Patient/legal Guardian/other Authorized Representative)

Name_____ Date_____

Address_____

_____

Home Phone#_____

Employer_____

Employer Phone#_____

FAMILY HISTORY – Has any blood relative had any of the following:
Circle 'yes' or 'no' - If so, what relationship:

Anemia	yes	no	_____
Bleeding tendency	yes	no	_____
Leukemia	yes	no	_____
Repeated infections	yes	no	_____
Crippling arthritis	yes	no	_____
Heart Disease	yes	no	_____
Chronic lung disease	yes	no	_____
Tuberculosis	yes	no	_____
High Blood Pressure	yes	no	_____
Kidney disease	yes	no	_____
Asthma	yes	no	_____
Severe Allergies	yes	no	_____
Mental Illness	yes	no	_____
Convulsions or fits	yes	no	_____
Migraine Headaches	yes	no	_____
Diabetes	yes	no	_____
Gout	yes	no	_____
Obesity	yes	no	_____
Thyroid trouble	yes	no	_____
Peptic ulcer	yes	no	_____
Chronic diarrhea	yes	no	_____
Cancer	yes	no	_____

_____

Have you ever had:			**Year**
Measles	yes	no	
Mumps	yes	no	
Whooping Cough	yes	no	
Polio	yes	no	
Scarlet Fever	yes	no	
Diptheria	yes	no	
Meningitis	yes	no	
Infectious Mono	yes	no	
Valley Fever	yes	no	
Tuberculosis	yes	no	
Exposure to TB	yes	no	
Malaria	yes	no	
Bronchitis	yes	no	
Pneumonia	yes	no	
Pleurisy	yes	no	
Hepatitis (yellow jaundice)	yes	no	
Bladder Infect.	yes	no	
Rheumatic Fever	yes	no	
Kidney Disease	yes	no	
Hives	yes	no	
Hay Fever/sinusitis	yes	no	
Asthma	yes	no	
Emphysema	yes	no	
Arthritis	yes	no	
Back Trouble	yes	no	
High Blood Press.	yes	no	
Heart Disease	yes	no	
Anemia	yes	no	
Bleeding Tendency	yes	no	
Nose Bleeds	yes	no	
Ulcer	yes	no	
Cancer	yes	no	
Hemorrhoids	yes	no	
Blood Transfusion	yes	no	

Tonsils	yes	no
Appendix	yes	no
Gall Bladder	yes	no
Stomach	yes	no
Breast	yes	no
Uterus &/or Ovary	yes	no
Prostate	yes	no
Hernia	yes	no
Thyroid	yes	no
Varicose Veins	yes	no
Hemorrhoids	yes	no
Heart	yes	no
Other	yes	no
Injuries:		
Head	yes	no
Chest	yes	no
Abdomen	yes	no
Broken Bones	yes	no
Back	yes	no
Other	yes	no
Allergies (*are you allergic to*):		
Tetanus Antitoxin	yes	no
Penicillin	yes	no
Sulfa	yes	no
Other drugs	yes	no

List_____

_____

Foods	yes	no
Cosmetics	yes	no
Other	yes	no

Immunizations:			**Year**
Smallpox	yes	no	
Tetanus	yes	no	
Polio Shots	yes	no	
Polio Oral	yes	no	
Other	yes	no	

Do you have a Living Will?

Yes_____ No_____

History of Substance Abuse?

Yes_____ No_____

	Present Age or Age at Death	If living, health (good, fair, poor) If deceased, cause of death
Father		
Mother		
Brothers or Sisters		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Children		
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PERSONAL HISTORY

Birthplace_____ Date_____

Nationality_____ Religion_____

Marital Status_____ Health of spouse_____

Occupations_____

Exposure to toxic substances_____

Residence past 5 years_____

Education through_____grade Habits:Sleep_____hrs./per night

Recreation_____

Exercise_____

Average per day:

Alcohol (type)_____

Tobacco (type)_____

Tea, coffee_____

Medicines taken regularly_____

_____

_____

_____

_____

_____

_____

_____

Hospitalization and/or other illness:_____

_____

_____

_____

Have you had the following:

General

Tire easily, weakness	yes	no
Marked weight change	yes	no
Night sweats	yes	no
Persistent fever	yes	no
Sensitivity to heat	yes	no
Sensitivity to cold	yes	no

Skin

Eruptions (rash)	yes	no
Change in color	yes	no
Change in hair	yes	no
Change in nails	yes	no

Eyes

Trouble seeing	yes	no
Eye pain	yes	no
Inflamed eyes	yes	no
Double vision	yes	no
Worn glasses	yes	no

Ears

Loss of hearing	yes	no
Ringing in ears	yes	no
Discharge	yes	no

Nose

Loss of smell	yes	no
Frequent colds	yes	no
Obstruction	yes	no
Excess discharge	yes	no
Nosebleeds	yes	no

Mouth

Sore gums	yes	no
Soreness of tongue	yes	no
Hoarseness	yes	no

Breasts

Lumps	yes	no
Discharge	yes	no

Cardio-Respiratory System

Cough, persisting	yes	no
Sputum (phlegm)	yes	no
Bloody sputum	yes	no
Wheezing	yes	no
Chest pain or discomfort	yes	no
Pain on breathing while lying down	yes	no
Swelling of ankles	yes	no
Bluish fingers or lips	yes	no
High blood pressure	yes	no
Palpitations	yes	no
Vein trouble	yes	no

Digestive System-

Indicate average food selection each meal:

Breakfast_____

Lunch_____

Dinner_____

Changes in appetite	yes	no
Difficulty swallowing	yes	no
Heartburn	yes	no
Abdominal distress	yes	no
Belching or excess gas	yes	no
Abdominal enlargement	yes	no
Nausea	yes	no
Vomiting	yes	no
Vomiting of blood	yes	no
Rectal bleeding	yes	no
Tarry stools	yes	no
Jaundice	yes	no
Constipation	yes	no
Diarrhea	yes	no
Hemorrhoids	yes	no
Need for laxatives	yes	no

Genitourinary System

Increase in freguency of urination (day)	yes	no
Increase in freguency of urination (night)	yes	no
Feel need to urine without much urine	yes	no
Unable to hold urrine	yes	no
Pain or burning	yes	no
Blood in urine	yes	no
Lack of sex drive	yes	no

Endocrine

Thyroid trouble	yes	no
Adrenal trouble	yes	no
Cortisone treatment	yes	no
Diabetes	yes	no

Locomotor

Muscle cramps	yes	no
Muscle weakness	yes	no
Pain in joints	yes	no
Swollen joints	yes	no
Stiffness	yes	no
Deformity of joints	yes	no

Nervous System

Headaches	yes	no
Dizziness	yes	no
Fainting	yes	no
Convulsions or fits	yes	no
Nervousness	yes	no
Sleeplessness	yes	no
Depression	yes	no
Change in sensation	yes	no
Memory loss	yes	no
Poor coordination	yes	no
Weaknes or paralysis of muscles	yes	no

GYN-OB

Started menstruating at age_____Date fo last PAP test_____

Interval between periods_____days Duration_____days

Flow: light normal heavy Date of last period_____

Pain with periods: yes no Duration_____

Number of pregnancies_____ Number of miscarriages_____

Number of births_____

Wt. of babies at birth_____