Patient Financial Policy

Sun Eye Care, P.A.

Thank you for choosing Sun Eye Care, PA. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays: You are expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted. Payment for the patient responsibility of charges is expected in full at the time of your visit. If you request to be mailed a bill, a $20 fee will be applied.

Insurance Claims: Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company, as a courtesy we will file your insurance claim on an unassigned basis, meaning that the insurance company will reimburse you directly and payment in full will be due at the time of your visit. If we are unable to file the claim on an unassigned basis, and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If your insurance claim is not paid by your insurance company in a timely basis (less than 60 days) you will be responsible for payment. If we later receive payment, we will refund the amount to you.

Vision Plans: With the exception of VSP, we do not participate in vision plans.

Contact Lens Policy: The fitting of contact lenses incurs a separate charge from your eye exam. The fee does not include the supply of contact lenses or where appropriate trial lenses. The fee charged for a contact lens fitting varies based on the complexity of the contact lenses being fitted and whether you have any eye diseases increasing the complexity of the fit (for example keratoconus). Please ask for an updated list of our current fees prior to scheduling your contact lens fitting. Also, be aware that some lenses require that you return for a follow up visit to determine that the fitting is correct. Our current fee schedule outlines how many of these return visits will be covered by your payment of the fitting fee. If you fail to return for your follow-up fit, your prescription may not be released to you. Payment for contacts is required at the time they are ordered. If you later choose not to receive them or do not return for follow up fitting as requested, your payment will be refunded provided that the vendor will accept the return. If they charge any re-stocking fees, those fees will be passed along to you.

Non-Covered Services: Not all insurance companies cover all services. In the event that your insurance company determines that a service to be “non-covered” for whatever reason, you will be responsible for the payment of those non-covered services.

Referrals and Pre-authorizations: Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain a properly dated referral and/or preauthorization for the correct provider may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements such as changing the visit to self-pay or rescheduling of your appointment may be necessary if a referral is not obtained.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us or who present without an insurance card. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient’s responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Patient examinations for emergency conditions or follow-up from Emergency Room visits

will be seen without regard to ability to pay at the time of the visit, however for patients unable to pay, payment arrangements will be made on a case by case basis. Extended payment arrangements are available if needed and we contract with CareCredit as an alternate form of payment. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Third Party Billing: We do not do any third-party billing. Our relationship is with you and not with a third-party liability insurance (auto, homeowner, etc.). It is your responsibility to seek reimbursement for any such claims. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

Workers' Compensation: We do not contract with Texas Worker's Compensation, but on an emergency basis TWC may sometimes authorize payment for work related injuries.

Non-Texas Residents: AGREEMENT AS TO GOVERNING LAW AND FORUM

All patients not residing in Texas are hereby notified that (specifically New Mexico resident pursuant to New Mexico HB 270), as a condition of treatment you agree to be bound by Texas law. The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive in the event that you should elect to file a tort

Missed Appointments

Sun Eye Care, PA requests a 24-hour notice of appointment cancellation. Missed appointments which are not previously cancelled may be charged a fee of $25.00 depending upon the circumstances for the cancellation. Patients who repeatedly cancel or no-show for appointments may be discharged from the practice.

Returned Checks: The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies: Patients requesting copies of medical records may be charged depending upon the volume of the amount requested. Attorneys and Insurance companies will be charged a $15 fee, plus postage, plus: $.25 per page and $15 for an itemized bill.

Minors: The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy: It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account may be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection's costs including attorney fees and court costs.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient or Guardian Signature Date signed

Waiver of Liability Notice of Noncoverage:

Private Insurance ONLY

Sun Eye Care, P.A.

The **Waiver of Liability Notice** is **used** to provide voluntary notification of financial liability for items or services that your private insurance may not cover for the services(s) listed below. Your private insurance does not pay for all your healthcare costs. Private insurance only pays for covered items and services based on your benefits and it is the responsibility of the insured to be aware of covered benefits. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. However, you need to make a choice about receiving this/these health care item(s) or service(s).

Private Insurance may not pay for the following item(s) or service(s).

Visual Field Test **$118-169**	(CPT Codes: 92081, 92082, 92083)	Corneal Topography **$115**	(CPT Code: 92025)
OCT **$118**	(CPT Codes: 92133, 92134)	Fundus Photos **$136**	(CPT Code: 92250)
Tear Lab **$53-106**	(CPT Code: 83861)	Pachemetry **$111**	(CPT Code: 76514
B-Scan **$326**	(CPT Code: 76512)	Refraction Test **$42**	**OTHER:**

Reason for non-payment: Non-covered benefit service(s) and/or item(s)*:* _____

Please be advised that your insurance company will not decide whether to pay unless you receive the above item or services. If your insurance denies payment, you will be fully responsible for payment. That is, you must pay personally, either out of pocket or through any other insurance that you may have. You may appeal your insurance's decision.

Your private insurance allows that we may bill you for items or services and that you may have to pay the bill while your insurance makes its decision. If your insurance does pay, we will refund to you any payments made. The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain if you do not understand why your insurance may not pay.
- Ask us how much these items or services will cost you. (Estimated total cost: S_____)

PLEASE CHOOSE ONE OPTION

□ **YES**. _____ (Initial) I want to receive these items or services. Please submit my claim to my private insurance. I agree to accept financial responsibility in the event my insurance chooses not to pay.

□ **YES**. _____ (Initial) I want to receive these items or services, but do not bill my insurance. You will be asked to pay item(s) or service(s) at the time of service (***Discount Private Pay Rates Available***). I cannot appeal if insurance is not billed.

□ **NO**. _____ (Initial) I have decided not to receive these items or services. I understand that you will not be able to submit a claim to my insurance and that an appeal to my insurance will not be made.

_____ _____

(Patient Signature/Responsible Party) (Date)

_____ _____

(Witness) (Date)

Sun Eye Care, P.A.

Advance Beneficiary Notice of Noncoverage (ABN-GA)

Medicare requires that you are given this form to alert you that Medicare may not pay for the services(s) listed below. Medicare does not pay for all your healthcare costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. However, you need to make a choice about receiving this/these health care item(s) or service(s).

Medicare may not pay for the following item(s) or service(s).

Visual Field Test **$118-169** (CPT Codes: 92081, 92082, 92083)		Corneal Topography **$115** (CPT Code: 92025)	
OCT **$118**	(CPT Codes: 92133, 92134)	Fundus Photos **$136**	(CPT Code: 92250)
Tear Lab **$53-106**	(CPT Code: 83861)	Pachemetry **$111**	(CPT Code: 76514
B-Scan **$326**	(CPT Code: 76512)	Refraction Test **$42**	**OTHER:**

Reason for non-payment: Non-covered benefit service(s) and/or item(s)*:* _____

Please be advised that Medicare will not decide whether to pay unless you receive the above item or services. If Medicare denies payment, you will be fully responsible for payment. That is, you must pay personally, either out of pocket or through any other insurance that you may have. You may appeal Medicare's decision.

Medicare allows that we may bill you for items or services and that you may have to pay the bill while Medicare is making its decision. If Medicare does pay, we will refund to you any payments made.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain if you do not understand why Medicare may not pay.
- Ask us how much these items or services will cost you. (Estimated total cost: S_____)

PLEASE CHOOSE ONE OPTION

☐ **YES**. _____ (Initial) I want to receive these items or services. Please submit my claim to Medicare. I agree to accept financial responsibility in the event Medicare chooses not to pay.

☐ **YES**. _____ (Initial) I want to receive these items or services, but do not bill Medicare. You will be asked to pay item(s) or service(s) at the time of service. I cannot appeal if Medicare is not billed.

☐ **NO**. _____ (Initial) I have decided not to receive these items or services. I understand that you will not be able to submit a claim to Medicare and that an appeal to Medicare will not be made.

*This notice gives our opinion, not an official Medicare decision. If you have questions on this notice or Medicare billing, call 1-800-633-4227 / **TTY:** 1-800-486-2048. Signing below means that you have received and understand this notice. You also received a copy.*

_____ _____

(Patient Signature/Responsible Party) (Date)

_____ _____

(Witness) (Date)

Sun Eye Care, P.A.

Consent for Examination & Notice of Privacy Practices

Notice of Privacy Practices and HIPAA

This section summarizes the Notice of Privacy Practices adopted by Sun Eye Care, P.A. A complete written notice will be given to you upon your request. It can also be found on our website at www.suneyecare.com. The intent of the Notice of Privacy Practices is to inform you of how we use your protected health information.

In general, your protected health information is used for purposes of providing treatment, obtaining payment for treatment and conducting health care operations. Your protected health information may be used or disclosed only for those purposes unless you have given authorization or as otherwise permitted under HIPAA or as required by law. Examples of these additional disclosures include reporting potential risks to public health, reporting suspected abuse or neglect, releasing information in conjunction with judicial proceedings or for law enforcement purposes, for research purposes and for specified governmental functions.

You have rights under HIPAA regarding your protected health information which include the right to inspect and copy your protected health information, the right to receive confidential communications from this office, the right to receive an accounting of releases of your protected health information and the right to receive a paper copy of this notice. You also have the right to request amendments to and restrictions on uses and disclosures of your protected health information. However, such amendments and restrictions may be denied by this office as allowed or required under HIPAA. If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations to your health insurer. We will say "yes" unless a law requires us to share this information

The terms of this notice may be changed from time to time as required by law or as otherwise necessary. Any changes in the provisions of the Notice would be effective for all future protected health information and would be made available to patients via mail or direct in-person contact.

If you feel that your rights have been violated regarding the maintenance or disclosure of your protected health information, you may express your concerns to either or both the privacy officer of this office, Janene Moore, or to the Secretary of Health and Human Services. We will not retaliate or take action against you for filing a complaint.

_____ (Initials) I acknowledge that I have read and understood the Notice of Privacy Practices.

Consent for Use of Dilating Medication(s)

Dilating eye drops are used to enlarge the pupil to allow examination of the inside of the eye. Although occurring rarely, risks of these medications include allergic reaction, acute glaucoma, and systemic reactions including increased blood pressure, irregular or fast heart beats and dizziness. Additionally, use of dilating drops will cause blurry vision and light sensitivity which can make driving and certain work conditions hazardous after an eye exam for a period of 4 – 6 hours or more

However, if dilating eye drops are not used, the examination is sub-optimal and certain conditions such as macular degeneration, glaucoma and retinal tumors may go undiagnosed.

_____ (Initials) I consent to the use of dilating eye medications.

_____ (Initials) I decline the use of dilating eye medications.

Acknowledgement of Refraction Policy and Consent for Refraction

Medicare policy requires that refraction (the exam to determine glasses prescription) be billed separately from an eye exam. Medicare and most commercial insurance carriers do not pay for refraction. Patients are responsible for payment of a refraction unless they have a vision plan which covers routine eye care services. Payment is due in full at the time refraction services are rendered.

If you decline having a refraction, there is a greater risk that there may be a delay in diagnosis of some eye diseases which may cause long term vision impairment. Further, declining refraction prior to some surgeries may result in non-payment of the surgery by your insurance carrier or Medicare in which case you would be responsible for payment.

Charge for Refraction as of 01/01/19: $42.00

_____ (Initials) I acknowledge that I have read and understood the refraction policy.

_____ (Initials) I consent to refraction when determined appropriate by my physician.

_____ (Initials) I decline refraction at this time.

Financial Responsibility & Consent for Treatment

It is the policy of Sun Eye Care, P.A. that payment is due at the time services are rendered. As a benefit to you we will bill services directly to your insurance carrier. However, you are ultimately responsible for all charges including, in the event of default, costs of collection and attorneys' fees.

I hereby authorize the assignment of medical and surgical procedures benefits from Medicare, Medicaid, other governmental insurances and/or private insurance to: Sun Eye Care, P.A., 5920 Cromo Dr El Paso, TX 79912.

I authorize Dr. Foote, Dr. Barentine, Dr. Krinkey, Dr. Weber, Dr. Kircher, Dr. Kim, or Dr. Mehta to provide reasonable and appropriate medical and surgical care consistent with the standards of care of the American Academy of Ophthalmology.

_____ _____

(Signature of Patient or legal guardian) (Date)

_____ _____

(Signature of Witness) (Date)

_____ (Initials) I have read and understood this entire document.

_____ (Initials) This document was read to me by: _____.

_____ (Initials) This document was presented to me in my native language.

Sun Eye Care, P.A.

CONSENT & DIRECTION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

In compliance with the HIPAA (Health Insurance Portability and Accountability Act) and to help protect your financial and health information, we ask that you complete this form. You may change your answers to this form at any time. We will keep a digital copy on file in your chart. We will endeavor to follow your wishes except when required by law as is described in the Notice of Privacy Protection statement which you have read and signed.

With regard to release of your health information, please read through the lists below and check the box that reflects your wishes.

During Examination

You (Sun Eye Care, PA) may speak with any and all persons accompanying me during my examination directly and/or allow them to hear all information or discussions indirectly. I understand that if I don't want that person privy to the conversation, I must ask that person to leave the exam room.

◯ Yes ◯ No

There are certain persons with whom I prefer you do not speak regarding my medical information while I am examined:

◯ Yes ◯ No

Name: Relationship

_____

_____

Telephone Contacts

I consent to receiving any and all information regarding appointments, laboratory, radiology and other testing results as well as financial information, including reminders for outstanding bills on my home telephone line and/or personal cellular phone.

◯ Yes ◯ No

Please restrict information as follows:

_____

_____

You may leave voice mail messages or messages on my answering machine with regard to appointments, laboratory, radiology and other testing results as well as financial information.

◯ Yes ◯ No

If no, please list restrictions below:

_____

How may we leave the above information for you then?

_____

_____

You may speak with or leave messages for me with any and all family members or significant others whether calling me as explained above or when or if they call with specific questions about my care.

◯ Yes ◯ No

Except for in the event of an emergency, please restrict the information you leave as follows and/or do not speak with the following people:

_____

_____

Electronic Media

You may contact me by various methods including e-mail, text messages or other internet or networking contact information that I leave with you and you may forward any information described above. Note that PHI will not be released into what is felt by us (Sun Eye Care, PA) to be a "non-secure" mode of transmission.

◯ Yes ◯ No

Please restrict information or mode or media transmission as follows:

_____

_____

Other Restrictions

I request restrictions on release of PHI as noted below:

_____

_____

_____

_____ _____

(Patient Signature) (Date)

Sun Eye Care, P.A.

NEW PATIENT MEDICAL HISTORY

Who is your primary care physician?

Name_____

Address_____

Who referred you to see us?

Name_____

Address_____

Pharmacy:_____

Address:_____ Phone #:_____

PAST EYE HISTORY

Have you ever had any eye injuries in the past?	Yes	No
Did this injury require treatment?	Yes	No
Did you lose vision as a result of the injury?	Yes	No

Please describe the injury: _____

_____

_____

Were you diagnosed with any eye problems in infancy or childhood such as “lazy eye” (amblyopia), an in-turning or out-turning eye (strabismus), retinal disease from premature birth (ROP) or any inherited eye abnormalities?

◯Yes ◯No

Did this problem require treatment?	Yes	No

Please describe the problem and treatment:

_____

_____

Do any eye diseases run in your family such as macular degeneration, glaucoma or other inheritable conditions?

◯Yes ◯No

If so, please list them:

_____

_____

_____

Do you wear glasses or contacts?	Yes	No

If no, did you wear glasses or contacts in the past? Yes No

What eye conditions do you currently have (such as glaucoma, cataract, diabetic eye disease, macular degeneration)? Please list them below and the approximate year you were diagnosed with the condition.

Name of condition	Year diagnosed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list below any eye surgeries or LASER treatments that you have had. Give the name of the surgeon and the approximate year of the procedure. (For example, glaucoma surgery, cataract surgery or LASER treatment for diabetes)

Type of surgery	Surgeon	Year performed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list below any drops, ointments or other medicines you are taking for your eyes.

_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History:

Please list below any medical conditions with which you have been diagnosed. Also give the approximate year of diagnosis and who is currently treating the problem (if different from your primary physician listed above).

☐ None

Name of condition	Treating physician	Year diagnosed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have diabetes,

When were you diagnosed?

Do you use insulin?	Yes	No
Has your blood sugar been difficult to control?	Yes	No
Has the diabetes caused any damage to your kidneys, heart or feet?	Yes	No
Have you ever been diagnosed with Graves' disease or other thyroid problems?	Yes	No
If you have had a stroke?		
Did you lose vision as a result?	Yes	No
Did the stroke affect the movement of your eyes?	Yes	No
Have you ever been diagnosed with multiple sclerosis or optic neuritis?	Yes	No
Have you been diagnosed with myasthenia gravis?	Yes	No
Have you ever been diagnosed with autoimmune problems such as lupus, Sjogren's syndrome, rheumatoid arthritis, Reiter's syndrome, Behcet's disease or ankylosing spondylitis?	Yes	No

Please list hospitalizations below (please give the year and reason):

_____
_____
_____
_____

List your current medications.

_____	_____
_____	_____
_____	_____
_____	_____

Please list all non-eye surgeries below.

Type of surgery	Surgeon	Year performed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any drug allergies? (Give the name and describe the reaction below.)

_____

_____

_____

FAMILY & SOCIAL HISTORY

Please list any family medical problems such as diabetes, cancer or heart disease below.

Family Member	Name of Condition or cause of death
_____	_____
_____	_____
_____	_____
_____	_____

How much alcohol or tobacco do you currently use?

Alcohol_____

Tobacco_____

Do you use any street drugs?

Type_____

Do you live ☐ alone ☐ with family ☐ assisted living ☐ Other _____

Are you ☐ single ☐ married ☐ widowed ☐ divorced

What type of work do you do? _____

Who is your employer? _____

REVIEW OF SYSTEMS: Please check any of the following that apply

GENERAL SYMPTOMS

- ❑ Good general healthy lately
- ❑ Recent unplanned weight change
- ❑ Decreased appetite
- ❑ Fever or night-sweats
- ❑ Fatigue, weakness or falling
- ❑ Obesity

ALLERGIC/IMMUNOLOGIC ☐ N/A

History of skin reaction or other adverse reaction to:

- ❑ Penicillin or other antibiotics
- ❑ Morphine, Demerol or other narcotics
- ❑ Novocaine or other anesthetics
- ❑ Aspirin or other pain remedies
- ❑ Tetanus antitoxin or other serums
- ❑ Iodine, merthiolate or other antiseptic
- ❑ Other drugs/medications:_____

Known food allergies: _____

Environmental allergies: _____

CARDIOVASCULAR ☐ N/A

- ❑ Heart problems or chest pain
- ❑ Palpitation or irregular heart beat
- ❑ Shortness of breath with walking
- ❑ Shortness of breath at rest or when lying flat
- ❑ Swelling in ankles, feet or hands

EARS/NOSE/THROAT ☐ N/A

- ❑ Hearing loss or ringing
- ❑ Earaches or drainage
- ❑ Chronic sinus problems
- ❑ Nose bleeds
- ❑ Mouth sores
- ❑ Sore throat or voice change

ENDOCRINE ☐ N/A

- ❑ Hormone or "gland" problem
- ❑ Thyroid disease
- ❑ Heat or cold intolerance
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Excessive thirst or urination

GASTROINTESTINAL ☐ N/A

- ❑ Change in bowel movements
- ❑ Nausea or vomiting
- ❑ Frequent diarrhea
- ❑ Painful bowel movements or constipation
- ❑ Rectal bleeding or blood in stool
- ❑ Abdominal/belly pain
- ❑ Ulcers

GENITOURINARY ☐ N/A

- ❑ Frequent urination or awaken at night to urinate
- ❑ Burning or painful urination
- ❑ Blood in urine
- ❑ Incontinence or dribbling
- ❑ Sores or discharge
- ❑ Kidney stone
- ❑ Sexual difficulty
- ❑ Male – testicle pain/lumps
- ❑ Male – discharge from or sores on penis
- ❑ Female – painful or irregular periods
- ❑ Female – prior abnormal pap smear
- ❑ Female – vaginal discharge

Female – number of pregnancies_____

Female – number of miscarriages:_____

Female – date of last pap smear_____

HEMATOLOGIC/LYMPHATIC ☐ N/A

- ❑ Slow to heal after cuts
- ❑ Bleeding or bruising tendency
- ❑ Anemia
- ❑ Blood clots
- ❑ Blood transfusion
- ❑ Enlarged glands

INTEGUMENTARY ☐ N/A

- ❑ Rash or itching
- ❑ Change in skin color
- ❑ Change in hair or nails
- ❑ Varicose veins
- ❑ Breast lump or pain
- ❑ History of abnormal mammogram

MUSCULOSKELETAL ☐ N/A

- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Weakness of muscles or joints
- ❑ Muscle pain or cramps
- ❑ Back pain
- ❑ Difficulty in walking
- ❑ History of bone fracture

NEUROLOGIC ☐ N/A

- ❑ Frequent or recurring headaches
- ❑ Light-headed or dizzy
- ❑ Convulsions or seizures
- ❑ Numbness or tingling sensation
- ❑ Shakes
- ❑ Paralysis
- ❑ Stroke
- ❑ Head injury

OCULAR ☐ N/A

- ❑ Eye disease or injury
- ❑ Wear glasses or contact lenses
- ❑ Blurred or double vision
- ❑ Glaucoma or cataracts

PSYCHIATRIC ☐ N/A

- ❑ Memory loss or confusion
- ❑ Nervous or anxious
- ❑ Worry about job, money, children or marriage
- ❑ Depression, frequent crying or easily upset
- ❑ Difficulty sleeping

PULMONARY ☐ N/A

- ❑ Chronic or frequent cough
- ❑ Exposure to tuberculosis or active tuberculosis
- ❑ Spitting up blood
- ❑ Shortness of breath
- ❑ Asthma or wheezing

OTHER

- ❑ _____

REVIEWED BY: _____ DATE: _____