

Christine D. Brown, M.D., P.A.

3801 Gaston Avenue, Suite 302 ♦ Dallas, TX 75246 ♦ Phone (214) 828-0016 ♦ Fax (214) 828-4883

PATIENT INFORMATION (Please print clearly)

Patient's Name	Marital Status	Sex	Date of Birth	Social Security #
	S M W Div Sep	M F		
Street Address	City and State		Zip Code	Home Phone #
Patient's Employer	Occupation (indicate if student)			Business Phone #
Employer's Street Address	City and State		Zip Code	Other Phone #
Emergency Contact (not living with you)	Relationship			Emergency Contact Phone #
Spouse's Name	Occupation		Spouse Date of Birth	Spouse Contact #
Primary Care Physician	Physician Address			Physician Phone #
Who referred you to this practice?	Email Address			Drivers License Number

IF THE PATIENT IS NOT THE INSURED:

Responsible Party's Name	Marital Status	Sex	Date of Birth	Social Security #
	S M W Div Sep	M F		
Street Address	City and State		Zip Code	Home Phone #
Patient's Employer	Occupation (indicate if student)			Business Phone #
Employer's Street Address	City and State		Zip Code	Relationship to Patient

PRIMARY INSURANCE:

Name of Insurance Co.	Phone # (to verify benefits)	Phone # (for pre-certification)
Address	City and State	Zip Code
Name of Insured	ID #	Group #

SECONDARY INSURANCE:

Name of Insurance Co.	Phone # (to verify benefits)	Phone # (for pre-certification)
Address	City and State	Zip Code
Name of Insured	ID #	Group #

PHARMACY BENEFITS INFORMATION:

Name of Insurance Co.	Phone # (to verify benefits)	Phone # (for pre-certification)
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS: I hereby authorize Christine D. Brown, M.D. to furnish appropriate and necessary details of medical information to my insurance company. I hereby authorize payment of medical benefits to Christine D. Brown, M.D. for medical services rendered.

Patient Signature: _____

Date: _____

Parent or Guardian: _____

Date: _____

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FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing our office for your care. We appreciate the opportunity to serve your health care needs and look forward to getting to know you. If you have any questions or concerns, please feel free to discuss these with our staff. Our philosophy is to provide personalized, high quality healthcare in the most cost-effective manner.

This form was developed to explain and clarify our financial policies. Please read this carefully and sign on the next page where indicated. Your signature indicates that you have read and understood our policies and that you will honor the terms. We appreciate your cooperation.

Standard Payment Policy:

Payment for our office visits is due at the time services are rendered. For your convenience, we accept VISA, MASTERCARD, and DISCOVER. We will provide you with an itemization of charges that you may submit to your insurance carrier for reimbursement of fees.

For Medicare patients, our office accepts assignment and files claims with Medicare. Medicare patients are responsible for any coinsurance and deductible amounts. Medicare patients must present their Medicare card at the time of registration. We do file secondary insurance for Medicare patients.

If you are an HMO/PPO (managed care) patient of a plan in which we participate, our office has agreed to accept the plan's fee schedule and file the claim with your insurance company. HMO/PPO patients are responsible for co-pays and deductibles at the time of service. HMO/PPO patients must present their insurance card at the time of registration. HMO/PPO patients are responsible for obtaining a referral number from your primary care physician.

Payment Policy:

Mohs and other surgery patients: We file insurance claims (including Medicare) for all surgery patients. We inform you of estimated deductibles and co-insurance amounts. These amounts are due at the time of service. Any balance due from the patient that is still remaining once insurance has paid its portion will be billed to you.

Insurance Claims:

We make every effort to seek insurance reimbursement on covered services. Filing insurance is a service we provide to you; however, insurance is a contract between you and your carrier. Once your insurance company has paid, you will receive a bill for any remaining balance on the account.

Collection Efforts:

We work with you to make payment arrangements. If these efforts do not result in a resolution of the account, the account may be referred to a collection agency and the local credit bureau. Any collection fees incurred by our office are charged to your account. An 18 percent annual service charge is added to balances over 30 days old.

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Returned Checks:

A service fee of \$35.00 is charged on all returned checks. You will be afforded the opportunity to remit the total of the check plus the \$35.00 fee in the form of cash, cashier's check, or money order on a timely basis. Our office policy is such that failure to comply with the above may result in your check being turned over to the Dallas County District Attorney's office for collection.

Missed or Cancelled Appointments:

If you do not appear for your appointment, or if you cancel your appointment with less than 24 hours' notice, you will be billed a \$40.00 "missed appointment" fee.

"Not Medically Necessary" or "Cosmetic" Procedures:

Insurance companies have instituted restrictions on procedures and have designated these as "not medically necessary." Procedures that commonly fall into this category are listed below:

- Removal of benign lesions, including moles, warts, skin tags, cherry or spider angiomas, lentigines (liver spots), cysts, and seborrheic keratoses by any procedure.
- Collagen treatments
- Glycolic acid peels
- Surgery to repair a torn ear (due to earrings)
- Laser surgery for any benign lesion
- Sclerotherapy for leg veins
- Cautery for treatment of dilated blood vessels of the face

If you elect to continue with a procedure in this non-covered category, payment in full is required at the time the service is rendered. There is no reduction in our standard fee schedule for managed care of Medicare patients. Medicare patients will be required to sign a separate acknowledgement statement as required by Medicare guidelines. Our office does not file a claim with your insurance carrier when any of these procedures are performed.

I have read and understand the above and agree to comply with the financial policies of Christine D. Brown, M.D., P.A.

Signature of Patient (or parent)

Date

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**PATIENT INSTRUCTIONS
WAIVER**

Please complete the enclosed information form prior to your appointment date and return it to us as soon as possible.

Include a **photocopy of the front and back of your insurance card(s)** and bring your insurance card(s) with you at the time of your appointment.

If you have an **HMO type plan**, be sure you have **a current referral from your primary care physician**. This will help us ensure that you see Dr. Brown at your scheduled appointment time. If you do not have **a valid referral** by the time of your appointment, **your appointment will be rescheduled**.

You will also need to bring **\$2.00** in dollar bills or quarters (**exact change only**) in order to exit from the parking garage in our building.

Thank you in advance for your assistance in getting the medical information forms to us as soon as possible.

I have read and understand the information provided to me herein.

Signature of Patient (or parent)

Date

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Social History Questionnaire

Do you drink alcohol? Yes or No

Amount: _____ servings per week Type: _____

Do you use illegal drugs? Yes or No

Do you smoke or use tobacco products? Yes or No

Amount: _____ packs per day Type: _____

Have you ever had skin cancer? Yes or No

What type? Basal Cell Squamous Cell Melanoma Other: _____

Has anyone in your family had skin cancer? Yes or No

Family Member(s): _____

What type? Basal Cell Squamous Cell Melanoma Other: _____

Do you have a history of any skin disease? Yes or No

Have you ever been exposed to HIV (AIDS)? Yes or No

Do you have artificial joints? Yes or No

Have you ever had dental anesthesia? Yes or No

Do you bleed easily? Yes or No

Do you have medication allergies? Yes or No

(Women) Are you pregnant? Yes or No

Height: _____ Weight: _____

Race: Asian Black Caucasian Hispanic Native American Other: _____

Please list your occupation: _____

Do you have occupational exposure to chemicals or petroleum? Yes or No

Do you have occupational exposure to arsenic? Yes or No

Occupational sun exposure: Mild Moderate Severe

Recreational sun exposure: Mild Moderate Severe

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Medical History

Please check the box marked “**Current**” if you are **currently experiencing problems** with any of the conditions below. Please check the box marked “**Past**” if you have **previously been diagnosed** with any of the conditions below. Please check the box marked “**Family Hx**” if the **condition runs in your family and indicate which family member**.

Cardiovascular	Current	Past	Family Hx/member	Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial Valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmurs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	Current	Past	Family Hx/member	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constitutional	Current	Past	Family Hx/member	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine	Current	Past	Family Hx/member	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Mouth/Throat	Current	Past	Family Hx/member	Yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	Current	Past	Family Hx/member	_____
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flank pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision loss/Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Medical History (Continued)

Hematological	Current	Past	Family Hx/member	Neck	Current	Past	Family Hx/member
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Carotid bruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Clotting problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Carotid surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Neck pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Integumentary	Current	Past	Family Hx/member	Neurologic	Current	Past	Family Hx/member
Skin Color changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Hair/nail changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Keloid tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Warts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Hives or eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Psychiatric	Current	Past	Family Hx/member
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Immunologic	Current	Past	Family Hx/member	Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
AIDS/HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Allergy treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Mood changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Hx of Psych care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Organ transplants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Typhoid fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Musculoskeletal	Current	Past	Family Hx/member	Respiratory	Current	Past	Family Hx/member
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Joint redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Loss of motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Spine surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Bone/joint disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	TB exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____				

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Medical History (Continued)

When listing items here, please print clearly in black ink.

Please list any allergies to medications:

Please list all medication that you take (include dosage and frequency):

Please list all surgeries and corresponding dates:

Including:

- | | | |
|---|-------------|-----------------|
| <input type="checkbox"/> Internal Cardiac Defibrillator | Date: _____ | |
| <input type="checkbox"/> Heart-valve Replacement | Date: _____ | |
| <input type="checkbox"/> Pacemaker Insertion | Date: _____ | |
| <input type="checkbox"/> Venous Filter | Date: _____ | |
| <input type="checkbox"/> Cardiac/Vascular Stent | Date: _____ | Location: _____ |
| <input type="checkbox"/> Coronary Arterial Bypass Graft | Date: _____ | Location: _____ |
| <input type="checkbox"/> Heart Transplantation | Date: _____ | |
| <input type="checkbox"/> Lung Transplantation | Date: _____ | |
| <input type="checkbox"/> Liver Transplantation | Date: _____ | |
| <input type="checkbox"/> Kidney Transplantation | Date: _____ | |
| <input type="checkbox"/> A-V Fistula | Date: _____ | |
| <input type="checkbox"/> Synthetic Vascular Graft | Date: _____ | |
| <input type="checkbox"/> Total Joint Replacement | Date: _____ | Location: _____ |
| <input type="checkbox"/> Shunt | Date: _____ | Location: _____ |
| <input type="checkbox"/> Orthopedic Hardware Implant | Date: _____ | Location: _____ |
| <input type="checkbox"/> Other Implant | Date: _____ | Location: _____ |