TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE F. INDIRA BAYNE, D.C.
3300 FM 1765 TEXAS CITY, TX 77590 (409) 948-3094 CLINIC (409) 948-8574 FAX

PATIENT DEMOGRAPHIC INFORMATION

How Did You Hear About Us or Referred By: ________________

Name____ Social Security #____________________
Last First Middle

Address____
Street City State Zip

Phone (H) ______________ (C) ______________ Email: __________________ Date of Birth ________

Sex __Male __Female Marital Status __ Married __ Single __ Divorced __Widowed Driver's License #______________

Employer____ Work Number____________________

Employer Address____
Street City State Zip

PRIMARY CARE PHYSICIAN:______________________________ Phone: ______________________

Address: ______________________________ Speciality: ________ Date Last Seen: __________

RESPONSIBLE PARTY: **PLEASE FILL OUT IF NOT SAME AS PATIENT** (INSURED POLICY HOLDER, OR PARENT/GUARDIAN)

Name____ Social Security #____________________

Address____
Street City State Zip

Date of Birth__________________ Sex ___Male___Female Relationship to Patient ____Self ____Spouse ____Child ____Other

Employer______________________________ Work Phone______________________

Employer Address____
Street City State Zip

INSURANCE INFORMATION:

Medicare Ins Co & Number ______________________ Medicaid Ins Co. & Number______________________

Primary Insurance Name ______________________ Insurance Phone #______________________

Insurance Policy/ID Number______________________ Group #______________________

Insurance Address____
Street
City State Zip

EMERGENCY CONTACT INFORMATION:

Name______________________________ Relationship________ Phone (H) ____________ (C) ______________

I GIVE **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE -- F. INDIRA BAYNE, D.C.** PERMISSION TO RELEASE DEMOGRAPHIC INFORMATION TO HOSPITAL, LABORATORIES, AND RADIOLOGY AS NEEDED TO SCHEDULE TESTS OR OTHER MEDICAL PROCEDURES FOR ME.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

____
PATIENT'S SIGNATURE DATE

______________________________ ______________
Doctor's Signature Date

TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE F. INDIRA BAYNE, D.C.
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PATIENT PERSONAL, FAMILY & SOCIAL HISTORY

Date ________________

Information contained herein will not be released except as you have authorized and will be used by your doctor in decisions regarding your care, so please answer all questions honestly and to the best of your knowledge.

Last Name:______________ First Name:______________ Middle:____________ Age:_____ Ht:_____ Wt:_____

Marital Status: S ☐ M ☐ W ☐ D ☐ Separated ☐ Sex: ☐ M ☐ F

Do you have or have you had: *Please circle all that apply* (If yes, give date of occurrence)

Stroke	Rheumatic Heart	Congenital Heart	Colitis	Sleep Apnea
Hay Fever	Migraine	Asthma	Diarrhea	Excessive Drowsiness
Bleeding Tendency	Tuberculosis	Blood Clots	Pneumonia	Loud Snoring
Bronchitis	Thyroid Problems	High Blood Pressure	Cancer	Shortness of Breath
Seizures	Bladder Infection	Anxiety or Depression	Heart Attack	Chest Pain
Diabetes	Arthritis	High Cholesterol	Stomach Ulcers	Heart Failure
Kidney Disease	Tonsillitis	AIDS/+HIV	Glaucoma	Gall Stones
Leukemia	Broken Bones ______________	Depression	Anxiety	Suicide Attempt

Is this visit as a result of an **injury** or **accidents**: **Auto**_____ Date ____________ Work Related _____ Date ____________
Other Type of Injury: ____ Describe Details ____ Date ________.

Primary Reason for This Visit? 1st) ____ Date of Onset ____________

2nd) ________________________ 3rd) ________________________ 4th) ________________________

Have you had treatment for this condition? Y __ N __ If so What? ________________________________

Doctor's Name: ____________________ Speciality: ______ When Seen? _________ Dr. Phone Number: __________

PAIN LEVEL TODAY (0 NO PAIN / 10 WORST PAIN ER)..............1 2 3 4 5 6 7 8 9 10 (W OR W/O MEDS)

Type of Pain/Condition? Dull * Aching * Sharp * Burning * Throbbing * Nagging * Numbness * Tingling * Radiate * Move Around

Name and Dates of all **operations** you have had:____.

Name any **drugs** to which you are allergic:____.

Serious **illnesses** you have had:____.

Serious **injuries** or accidents:____.

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?

Aspirin, Advil, Anacin	Laxatives	Seizure medicine	Blood pressure pills
Sleeping pills	Shots	Cortisone	Thyroid medicine
Water pills	Chough medicine	Headache pills	Antibiotics
Digitalis	Medicine for arthritis	Cold medication	Hormones
Tranquilizers	Birth control pills	Insulin or diabetic pills	Weight reducing pills
Pain medicine	Iron	Poor blood medication	Blood thinning pills
Over the counter med	Vitamins	Medicine for depression	Eye drops
Ulcer medicine	Cholesterol medicine	Other drugs not listed	Other medicine ________.

Please check all that apply:

YES ☐ NO ☐ If you smoke or have you ever smoked, How much?_____ How many years?____ If quit, when?________
YES ☐ NO ☐ Date of last chest X-Ray________________________________
YES ☐ NO ☐ Do you usually drink over 6 cups of caffeinated beverages per day?____________________

____________________ ____________
Doctor's Signature Date

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F. INDIRA BAYNE, D.C.
(409) 948-8574 FAX

Please check all that apply:

YES ☐ NO ☐ Do you regularly drink alcohol, wine, or beer? How much?____________________
YES ☐ NO ☐ Do you exercise regularly? What and How Often?____________________
YES ☐ NO ☐ Do you sleep well? Mattress Age ___________
YES ☐ NO ☐ Do you have pets? Birds __ Cats __ Dogs __ Other __
YES ☐ NO ☐ Do you use recreational drugs? What ____________________
YES ☐ NO ☐ Do you eat regularly? Times a Day? 1_ 2 _ 3 _ Healthy?____ Healthy Sometimes? ___ Fast Food? _____
YES ☐ NO ☐ Do you have regular recreation time? Type?____________________
YES ☐ NO ☐ Do you spend time in Nature or Fun? Beach _ Fishing _ Golf _ Lakes _ Tennis _ Walking _Other _
YES ☐ NO ☐ What type of work do you perform? __________________ Work Schedule __________________
YES ☐ NO ☐ Are you a student? Y N Elementary __ Middle School __ High School __ College __ Highest level _______
YES ☐ NO ☐ Do you have many friends? What do you do with them? ____________________
YES ☐ NO ☐ Do you vacation? Where? ____________________ When last time? ____________________
YES ☐ NO ☐ Do you visit the country or farms? When? __________________ Pet or See Farm Animals Y N

When do you feel the best? ____________________ Worst ____________________

FOODS/DRINKS ☐ **Artificial Sweeteners** **Crave** Salt or Sugar **Fast Foods,** How Often ______

Food Types Eaten Daily? Bread / Pasta / Fish / Red Meat / Fruie / Vegtables ____________________

☐ Sweets How Often? _____ ☐ Meals Eaten Per Day? ___ Times in the Day ______________

☐ **Energy Drinks** How Often? ___ ☐ **Sodas** Regular or Diet How Often? ___

☐ **Water** How Much Daily? _____

WOMEN ONLY

YES ☐ NO ☐ Are you NOW pregnant?
YES ☐ NO ☐ Are you having regular monthly menstrual cycles? If Yes Last cycle? ______________
YES ☐ NO ☐ If not, are you having symptoms of the menopause?
YES ☐ NO ☐ Have you ever had bleeding between your cycles? When?____________________
YES ☐ NO ☐ Do you have very heavy bleeding with your cycles? When?____________________
YES ☐ NO ☐ Have you ever or do you now had any vaginal infections? When?____________________
YES ☐ NO ☐ Are you now or have you ever taken birth control pills? When?____________________
YES ☐ NO ☐ Do you now or ever and a hernia? Where? ______________ Surgery repair? ______________

Date of last pap smear test __________________ Results ____________________

How many? Children born alive?____ Miscarriages?____ Stillbirths?____ C-Sections?___ Premature births?____

Any complications of pregnancy?____________________

MEN ONLY

YES ☐ NO ☐ Have you ever had problems with your testicles or scrotum?
YES ☐ NO ☐ Have you ever had a discharge from your penis?
YES ☐ NO ☐ Do you now or ever and a hernia? Where? ______________ Surgery repair? ______________
YES ☐ NO ☐ Have you had trouble with your prostrate (urinary frequency, hesitancy, or dribble)?

Any of your blood relatives have or had: ***Please circle all that apply*** **(if yes, give date of occurrence and relationship)**

Stroke	Rheumatic Heart	Congenital Heart	Colitis
Hay Fever	Migraine	Asthma	Diarrhea
Bleeding Tendency	Tuberculosis	Blood Clots	Pneumonia
Bronchitis	Thyroid Problems	High Blood Pressure	Cancer
Seizures	Bladder Infection	Anxiety or Depression	Heart Attack
Diabetes	Arthritis	High Cholesterol	Stomach Ulcers
Kidney Disease	Tonsillitis	AIDS/+HIV	Heart Failure
Glaucoma	Gall Stones	Leukemia	Suicide Attempt

____

PATIENT'S SIGNATURE DATE

______________________ ____________

Doctor's Signature Date

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HIPAA POLICIES AND PROCEDURES

NEW PATIENT CONSCENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATONS

TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE – F. INDIRA BAYNE, D.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that, **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE – F. INDIRA BAYNE, D.C.** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE – F. INDIRA BAYNE, D.C.** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information: ____

____.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

____________________ ____________________ ____________
Patient's Signature Patient Printed Name Date

____________________ ____________
Doctor's Signature Date

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HIPAA POLICIES AND PROCEDURES

HEALTH CARE AUTHORIZATION FORM

Patient's Name ______________________________

Patients SS# ______________________ Date of Birth __________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES, TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE -- F. INDIRA BAYNE, D.C. TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

☐ I give permission to **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE -- F. INDIRA BAYNE, D.C.** to use my address, phone number and clinical records to contact me with birthday cards, emails, holiday related cards and information about treatment alternatives or other health related information.

OPEN ROOM AUTHORIZATION

☐ I give **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE -- F. INDIRA BAYNE, D.C.** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private; the doctor will provide a room for these conversations.

☐ By signing this form you are giving **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE -- F. INDIRA BAYNE, D.C.** permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: ______________

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE -- F. INDIRA BAYNE, D.C.** A clear statement of your intent to revoke this AUTHORIZATION; requires the date of your request, your signature and the revocation is not effective until it is received by the Privacy Official. This AUTHORIZATION is requested by **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE -- F. INDIRA BAYNE, D.C.** for its own use/disclosure of PHI. You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE -- F. INDIRA BAYNE, D.C.** will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

Name of Patient	Signature of Patient	Date
Name of Guardian if Patient is a Minor	Signature of Guardian if Patient is a Minor	Date

Doctor's Signature Date

TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE F. INDIRA BAYNE, D.C.
3300 FM 1765 TEXAS CITY, TX 77590 (409) 948-3094 CLINIC (409) 948-8574 FAX

HIPAA POLICIES AND PROCEDURES
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

______________________ ________________________ __________
Patient Printed Name Patient Signature Date

[ ] Consent received by ______________________________ on _______________.
[ ] Consent added to the patient's medical record on ____________________________.

Attempt was made to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained due to:
[ ] Consent refused by patient treatment was rendered.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Communication barrier prohibited the acknowledgment.
[ ] Emergency situation prevented obtaining acknowledgment.
[ ] Other specify situation ____

________________________ __________________________ __________
Staff Printed Name Staff Signature Date

__________________________ __________
Doctor's Signature Date

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CHIROPRACTIC INFORMED CONSENT

The doctor after examination has explained the prescribed treatment plan to me (for myself or for my minor child) including the nature and purpose of the chiropractic adjustments as well as other treatments or procedures appropriate for the condition. I hereby request and consent to treatment from **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE – F. INDIRA BAYNE, D.C.** doctors and staff including chiropractic adjustments, manual therapy techniques and physical modalities including hydroculation (heat), cryotherapy (ice), ultrasound, neuromuscular reeducation, massage, rehab, examinations or other treatments and testing that the doctor determines to be appropriate for my condition or for my minor child's condition.

In particular you should note:

a) While rare, some patients have experienced rib fractures, muscle strains and/or ligament sprains **following spinal manipulation.**

b) There have been reported cases of injury to a vertebral artery following **cervical spinal adjustments**. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in death.

c) **Hydroculation (heat) and cyrotherapy (ice):** skin reactions or burns

Chiropractic treatments, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches being and other similar symptoms. The risk for injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor the nature and purpose of the treatments in general and myself or my minor child's treatment in particular (including spinal adjustments) as well as the contents of this Consent and I fully understand that there are no guarantees in medicine as to the outcome of any treatment. I consent to the treatment offered or recommended to me for myself or my minor child including spinal adjustments. I intend this consent to apply to all of my or my minor child's present and future care.

I understand and am informed that, as with any medical treatment and care, in the practice of chiropractic there are some risks. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment and procedures that the doctor feels appropriate for me at the time based on the facts know at the time, in my or my minor child's best interest.

I have read (or have read to me) the above consent. I have had an opportunity to ask any questions I had about its content, and by signing below I agree to begin treatment for myself or for my minor child, ______________________________.

I intend this consent form to cover the entire course of treatment for myself and/or my minor child's present condition and for any future condition (s) for which I may continue to seek treatment here at **TEXAN WELLNESS CHIROPRACTIC * ACUPUNTURE – F. INDIRA BAYNE, D.C.**

Patient Printed Name	Patient Signature	Date
Witness Printed Name	Witness Signature	Date

Doctor's Signature Date

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REVIEW OF SYSTEMS

PATIENT'S NAME______________________________ DATE __________

CARDIOVASCULAR: ☐ Angina ☐ Ankle Swelling ☐ Awakening At Night ☐ Cardiac Catheterization ☐ Chest Pains ☐ Congenital Heart Defects ☐ Cold Hands or Feet ☐ Dizzy When Standing Quickly ☐ Heart Attacks ☐ Heart Failure ☐ Heart Murmurs ☐ Heart Palpitations ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Irregular Heart Rate ☐ Leg Cramps ☐ Leg Pain That Stop with Rest ☐ Night Sweats ☐ Pain Left Side Arm/Face/Neck ☐ Pounding Heartbeat ☐ Rapid Heartbeat ☐ Purple Fingers or Lips ☐ Short of Breath ☐ Varicose Veins

EARS, & EYES,
☐ Ear Aches ☐ Ear Discharge ☐ Ear Infections ☐ Ear Pain ☐ Hearing Loss ☐ Ringing In Ears
☐ Cataracts ☐ Double Vision ☐ Eye Problems ☐ Glasses/Contacts ☐ Glaucoma ☐ Itchy, Red or Watery ☐ Night Vision Poor ☐ Pain In, Behind, Near

ENDOCRINE ☐ Abnormal Blood Counts ☐ Anemia ☐ Arthritis ☐ Changes In Skin Texture ☐ Diabetes ☐ Decrease/Increased Body Hair ☐ Decrease/Increase Facial Hair ☐ Decrease Head Hair (not male baldness) ☐ History of "Borderline" Diabetes ☐ Flushing / Hot Flashes ☐ Intolerance Cold ☐ Intolerance Heat ☐ Sickle Cell

GASTROINTESTIONAL ☐ Abdominal Pain ☐ Anal Fissures ☐ Belching ☐ Intestinal Bloating ☐ Gas/Flatulence ☐ Black Tarry Stools ☐ Constipation ☐ Diarrhea ☐ Feel Fatigue or Lethargic After Eating ☐ Gall Stones ☐ Heart Burn ☐ Hiatal Hernia ☐ Hemorrhoids ☐ indigestion ☐ Intestinal Obstruction ☐ Liver Disease ☐ Loss of Bowel Control ☐ Nausea ☐ Pain in Stomach, Intestines or Colon ☐ Poor Digestion ☐ Problems Swallowing ☐ Red Blood After Bowel Movement ☐ Rectal Bleeding, Itching or Bleeding ☐ Reflux ☐ Ulcers ☐ Vomiting Blood ☐ Vomiting

GENERAL ☐ Appetite Increased / Decreased ☐ Binge/ Compulsive Eating ☐ Change In Activity ☐ Change In Sleeping Patterns ☐ Excessive Tiredness ☐ Enlarged Lymph Nodes ☐ Fatigue (lack of energy or stamina) ☐ Frequent Infections ☐ Hypoglycemia (Low Blood Sugar) ☐ Increased Need for Sleep ☐ Insomnia ☐ Tired or Not Hungry When Waking ☐ Weight Gain ☐ Weight Loss

KIDNEYS & URINARY TRACT ☐ Bladder Problems ☐ Blood In Urine ☐ Brown Urine ☐ Dribbling After Urination ☐ Excessive Thirst ☐ Frequent Bladder Infection ☐ Involuntary Urination ☐ Kidney Disease ☐ Kidney Stones ☐ Painful (or Burning) Urination ☐ Urination Frequency (Day) ☐ Urination Frequency (Night) ☐ Urine Hesitancy ☐ Urinary Incontinence ☐ Urinary Tract Infections (UTI) ☐ Weak Flow

LUNGS ☐ Asthma ☐ Blood Clots in Lungs ☐ Bronchitis ☐ Coughing ☐ Chest Congestion ☐ COPD

MOUTH, NOSE, TEETH & THROAT
☐ Decrease taste / smell ☐ Gum Problems ☐ Oral Herpes ☐ Sores Mouth / Lips ☐ Swollen / Tender Tongue / Gums ☐ Swollen Glands
☐ Allergies to Animals ____________, Food ____________, Environment/Chemicals ____________ ☐ Hay Fever ☐ Nose Bleeds Freq ______
☐ Nasal Polyps ☐ Nose Runs ☐ Sinus Infections ☐ Sinus Pain
☐ Bad Breath ☐ Dentures ☐ Regular Dental Check-ups ☐ Mercury fillings ☐ Root Canals
☐ Coughing ☐ Drainage ☐ Excess Mucus ☐ Goiter ☐ Hoarseness ☐ Polyps ☐ Sore Throats ☐ Swollen Glands ☐ Voice Changes

MUSCULOSKELETAL ☐ Areas of numbness ________________ ☐ Areas of Pain ________________ ☐ Areas of Tingling ________________
☐ Back Pain ☐ Blood Clots in Legs ☐ Bone Marrow Biopsy ☐ Bursitis ☐ Easy Bleeding ☐ Easy Bruising ☐ Gout ☐ Joint Aches ☐ Joint Pain ☐ Joint Swelling ☐ Limited Motion in Joints ☐ Morning Stiffness ☐ Muscle Aches/Pain ☐ Muscle Weakness ☐ Muscle Cramps ☐ Neck Pain ☐ Night Pain ☐ Tendonitis

NEUROLOGICAL ☐ Anxiety ☐ Blackouts ☐ Change in Sensation On Your Body ☐ Confusion ☐ Depression ☐ Difficult In Talking ☐ Dizziness ☐ Epilepsy ☐ Fainting Spells ☐ Headaches ☐ Head Injuries ☐ Hyperactivity ☐ Learning Difficulty ☐ Loss of Consciousness ☐ Memory Loss ☐ Meningitis ☐ Near Blackouts ☐ Paralysis ☐ Pressure feeling in Head ☐ Seizures ☐ Strokes ☐ Tingling ☐ Tremors ☐ Weakness or Numbness

RESPIRATORY ☐ Asthma ☐ Breathlessness When Lying Flat ☐ Coughing Up Blood ☐ Emphysema ☐ Frequent Bronchitis ☐ Pleurisy ☐ Pneumonia ☐ Prolonged Cough ☐ Shortness of Breath ☐ Tuberculosis ☐ Wheezing

SKIN & NAILS ☐ Abscess ☐ Acne ☐ Athlete's Foot ☐ Boils ☐ Change in Skin Color ☐ Dandruff ☐ Dry Skin / Oily Skin ☐ Eczema ☐ Excessive Body Odor ☐ Excessive / Not Sweating ☐ Fungal Infections ☐ Hives ☐ Itchy Skin W or W/O Redness ☐ Jaundice ☐ Lumps ☐ Moles – Change ☐ Moles – Irregular ☐ Moles New ☐ Psoriasis ☐ Rashes ☐ Small Rough Bumps on Skin ☐ Nail Problems ☐ Weak Nails ☐ Ridged Nail

MALE & FEMALE ☐ Genital Herpes ☐ Groin Itching ☐ Loss of Sexual Interest ☐ Painful Sexual Intercourse ☐ Sexually Transmitted Disease (STD) ☐ Tested for HIV Y N ☐ Unprotected Sex

MALES ONLY ☐ Bloody Ejaculation ☐ Family History of Prostate Cancer Y N ☐ Hernia ☐ Inability to Complete Intercourse ☐ Lump On Testicle ☐ Penile Discharge ☐ Problems Maintaining or Keeping Erection ☐ Prostate Disease ☐ Slow Urine Stream ☐ Sores on Penis ☐ Sterility ☐ Testicular Pain ☐ Testes Undescended, In Abdomen or Pelvis ☐ Testicular Swelling ☐ Warts on Penis

FEMALES ONLY ☐ Abnormal Bleeding Between Cycles ☐ Abnormal PapTest ☐ Bleeding After Intercourse ☐ Complications With Pregnancy ☐ D&C ☐ Discharge From Breast ☐ Endometriosis ☐ Excessive Bleeding ☐ Fibroids ☐ Heavy Bleeding During Cycles ☐ Hernia ☐ Hot Flashes ☐ Infertility ☐ Irregular Periods ☐ Pain in Breasts ☐ Painful Periods ☐ Pain Between Periods ☐ Ovarian Cyst ☐ Pelvic Inflammatory Disease ☐ Post-Menopausal Symptoms ☐ (PMS) ☐ Vaginal Discharge ☐ Vaginal Dryness ☐ Vaginal Warts ☐ Water Retention ☐ Yeast Infections

______________________ Doctor's Signature ____________ Date