**PATIENT INFORMATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Initial Last

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_

Home # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holders DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holders DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S OR AUTHORIZED SIGNATURE**: I authorize the release of any medical information needed to process my insurance claims. I also request payment of benefits to Wiregrass Neurology for services rendered. This signature shall suffice for all claims on a continuing basis. A copy of this authorization may be used in place of original.

**SIGNED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF MEDICAL RECORD**: In order to insure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to Wiregrass Neurology, my physician, a designated referring physician and/or the provider, if any, who referred me here.

**SIGNED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:** I acknowledge that I have received or been offered a copy of the Notice of

Privacy Practices from Wiregrass Neurology.

**SIGNED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGREEMENT TO PAY**

The Patient listed below hereby agrees to pay any and all amounts and charges submitted by Wiregrass Neurology on behalf of the provider set forth above for services rendered by any and all providers who are now employed or become employed by Wiregrass Neurology, or any of their agents, employees or contractors, during the course of treatment for the Patient, including hospitalizations, unless such parties are otherwise obligated to accept payments solely from a third party. The Patient hereby acknowledge, understand, and agree that they are financially responsible for payment for such professional services even though there may be insurance or third party coverage, and agree that failure to make payment when requested is the basis for legal action, and agree to pay any and all costs of collection including reasonable attorney’s fee to the extent permitted by law. The Patient acknowledges that in the event the insurance company denies payment for all or part of services provided, Patient will be responsible for payment of said services. The Patient hereby acknowledges their understanding that the payment is due upon receipt of invoice statement. All copays and deductibles are due at the time services are rendered.

I, the undersigned, understand and agree to the above information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (Printed) Patient’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed

**MEDICAL INFORMATION RELEASE**

Due to federal privacy guidelines under the Health Insurance Portability and Accountability Act (HIPPA), we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to family members, caregivers, and friends you have designated, regarding your health information. Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, phone, fax, mail or email as needed for your care to only those identified below.

Please list names, date of birth, and phone numbers of the authorized individuals below. Do NOT list anyone who has not agreed to provide us with their date of birth for identification purposes.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my authorization to the following individual(s) listed below to discuss my medical care with you and/or your staff on my behalf.

NAMES DATE OF BIRTH PHONE NUMBER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list below any health information that you do NOT want to be given out.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** I DO NOT want you to discuss my medical care with ANYONE other than myself.**

Our office staff may attempt to contact you by telephone concerning your upcoming appointments or test results. If we are unable to reach you at that time, please indicate below your choice for the best way to contact you.

 Family member at my home  Voice message on my cell phone

 Leave a message at my place of business  Message on answering machine at my home

The above information is private and confidential and will be placed in your medical record. This authorization will expire twelve months from the date signed or until we receive written notification from you to revoke it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**NOTICE OF PRIVACY PRACTICES SUMMARY**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully. If you have any questions about this notice, please contact our Privacy Officer: Nikki Perkins, Office Manager, (334) 792-8679.

This is a summary of our Notice of Privacy Practices, which describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your personal health information as part of rendering patient care, including treatment, payment and healthcare operations (TPO).

Other uses and disclosures of your protected health information (PHI) will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to request a restriction of your protected health information.

You have the right to request to receive confidential communications of your protected health information.

You have the right to inspect and copy your protected health information. Charges to receive copies of your protected health information will be in accordance with practice policy which is in accordance with state and federal law.

You have the right to request to amend your protected health information. We also have the right to comment and respond to any amendments that you make to your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You have the right to obtain a paper copy of this Notice of Privacy Practices from us.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your compliant. We will not retaliate against you for filing a compliant.

This summary was published as supplement to our Notice of Privacy Practices.

As a patient of our practice, you have the right to a copy of our Notice of Privacy Practices, if you request one. We have the policy posted in our office waiting room for your reference.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have received or been offered a copy of the Notice of Privacy Practices from Wiregrass Neurology.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Printed Name of Patient or Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Relationship to Patient or Authority to Serve

Documentation or reason(s) patient refused to sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**PATIENT HISTORY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:  Shellfish  Iodine  IVP Dye  Latex  Food  Drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

Have **YOU**, the patient, ever **HAD** any of the following:

 Seizure  Carpal Tunnel  Anxiety  Urinary Incontinence  Epilepsy

 Rheumatoid Arthritis  Depression  Prostate Disease  Stroke  Myasthenia Gravis

 Memory Loss  COPD  Tremors  Cerebral Palsy  Bipolar Disorder

 Asthma  Parkinson’s Disease  Restless Leg  Dementia  Seasonal Allergies

 Multiple Sclerosis  Fibromyalgia  Alzheimer’s  GERD/Acid Reflux  Cervical Disc

 Vertigo  ADHD  Thyroid Disease  Arthritis  Fainting

 Diabetes  HIV/AIDS  Neuropathy  Sleep Apnea ( CPAP)  Dialysis

 Lumbar Disc  Insomnia  Kidney Disease  Kidney Stones  Gout

 High Blood Pressure  High Cholesterol  Heart Disease  Heart Palpitations  Heart Attack

 Asthma  Liver Problems  Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SYMPTOMS**

Please check ALL that apply

 Facial Pain  Neck Pain  Back Pain  Bone Pain  Dizziness

 Head Trauma  Neck Trauma  Back Trauma  Blackout  Difficulty Walking

 Shuffling Gait  Foot Drop  Loss of Balance  Vision Changes  Sensitivity to Light

 Difficulty Closing Eyes  Drooping Eyelids  Ringing in Ears  Hearing Difficulty  Tongue Bite

 Difficulty Swallowing  Difficulty Breathing  Shortness of Breath  Daytime Sleepiness  Numbness \_\_\_\_\_\_\_\_

 Tingling \_\_\_\_\_\_\_\_\_\_\_  Burning  Sciatica Pain  Muscle Weakness  Joint Swelling

 Headache  Migraine  Head Pain  Nausea  Vomiting

 Memory Loss  Change in Appetite  Nervousness  Mood Swings  Depression

 Panic Attack  Fatigue  Loss of Consciousness  Paralysis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Weakness of Limb(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Seizure Activity  Tremors  Syncope

 Sleep Disturbance

PLEASE CHECK IF THE VISIT IS RELATED TO:

 Motor Vehicle Accident  Workplace Accident

Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

State Accident Occurred: \_\_\_\_\_\_\_\_\_\_ Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do **YOU**, the patient:

**SMOKE**  Current (\_\_\_\_ packs per day)  Former **USE ALCOHOL**  Yes (If so how often: \_\_\_\_\_\_\_\_\_\_\_)  No, Never  No, I Quit

**ILLEGAL DRUG USE** Yes No, Never No, I quit **daily, weekly, monthly, socially, or rarely**

**CURRENT MEDICATIONS**

Please include all **CURRENT** medications including all insulin, over the counter medications, vitamins, and herbs along with their strengths and how often you take each of them.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PAST SURGICAL HISTORY**

Please include approximate dates

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY**

Please list your family’s medical history. This would be medical conditions, including but not limited to, high blood pressure, diabetes, high cholesterol, dementia, Parkinson’s, etc. Please list the relationship of the individual to the patient (mother, father, siblings, etc).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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