Comprehensive
Pain & Rehabilitation

4105 Hospital Road, Suite 112-A, Pascagoula, Ms 39581 P: 228-937-0700 * F: 228-938-0705

230 North Greeno Rd, Fairhope, Al 36532 P: 251-625-2228 * F: 251-625-2112

6701 Airport Blvd Building D, Suite 144, Mobile, Al 36608 * P: 251-625-2228 * F: 251-625-2112

www.nopaindr.com

New Patient Information

Patient Name: _____ Date: _____

Age: _____ Birth Date: _____SSN: _____

Marital Status: Single Married Divorced Widowed (Please circle one)

Patients Physical Address: _____

City: _____ State: _____ Zip: _____

Patients Mailing Address (If different from Physical) _____

City: _____ State: _____ Zip: _____

Phone (Home) _____ (Cell)_____ (Work)_____

Emergency Contact: _____ Relation: _____

Phone (Home)_____ (Cell)_____ (Work)_____

Employer Information:

Occupation: _____ Employer: _____

Address: _____

Phone: _____ Fax: _____

Insurance Information:

Primary Insurance Company: _____

Policy/Member # _____ Group # _____

Name of Insured _____ Relation _____

SSN of Insured _____ DOB of Insured _____

Secondary Insurance Company: _____

Policy/Member # _____ Group # _____

Name of Insured _____ Relation _____

SSN of Insured _____ DOB of Insured _____

Workers Compensation Information:

Date of Injury: _____ Area of Injury: _____

Are you currently Working? _____ Have you been placed on Disability?_____

Have you been placed on MMI?_____ Are there any restrictions?_____

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AGREEMENT OF PAYMENT

- I do hereby understand and agree that I am responsible for all fees billed to my account as a result of my treatment with Comprehensive Pain & Rehabilitation.
- I further understand that Comprehensive Pain & Rehabilitation will file any applicable claims as a matter of convenience. It is my responsibility to provide accurate and valid insurance information to Comprehensive Pain & Rehabilitation. Failure to provide accurate information may result in my responsibility for all charges to my account.
- I understand that it is my responsibility to provide referral from my Primary Care Physician should it be required by the insurance carrier.
- Comprehensive Pain & Rehabilitation will allow up to sixty (60) days for the insurance carrier to pay the claim. After the sixty (60) days, I understand that the charges for treatment may be transferred to my responsibility. I will be responsible for any unpaid balance in full each month unless other financial arrangements are made.
- I understand that should my account become past due and the account sent to an outside Collection Agency, I will be responsible for the account balance, attorney fees, court fees, and any other fees associated to the collection of this account.

I, _____, do hereby declare that I have read, understand and agree to the terms of this Agreement of Payment.

_____ _____

Patient Signature Date

_____ _____

Witness Date

CONSENT FOR PHOTOGRAPH

I, _____, give permission for Comprehensive Pain & Rehabilitation to take an identification photograph to be maintained in my medical records with Comprehensive Pain & Rehabilitation. I understand that this picture will be used in a confidential manner related only to my personal care in the above named office.

_____ _____

Patient Signature Date

Pain Consultants of Alabama LLC, dba, Comprehensive Pain & Rehabilitation

Referring Physicians Name _____ Patient's Home Phone _____ Cell Phone _____

Patients Street Address _____ City _____ State _____ Zip _____ County _____

Primary Insurance Company _____ Name of Insured _____

Secondary Insurance Company _____ Name of Insured _____

AUTHORIZATION FOR RELEASE OF RECORDS: I agree that Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation may disclose, to the extent allowed by law, my medical and financial record to (A) any affiliate of Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation including its employees, agents, and entities under contract with Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation to provide quality and/or utilization review; (B) any person or entity which may be liable under contract or by law to Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation or to me, or any entity responsible for all or part of the facility charges, specifically including any insurance company or their agents or employees; (C) any person or entity to whom I have been referred by Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation or by my physician for continued care; (D) any physician treating, consulting or performing services for me, including his or her employees and agents; (E) any governmental or accreditation agency, or their employees or agents.

IF YOU HAVE A SPOUSE, FAMILY MEMBER, FRIEND, GUARDIAN OR OTHER ENTITY WHO MAY NEED TO DISCUSS YOUR MEDICAL & FINANCIAL INFORMATION, OR WHO MAY REQUEST A COPY OF YOUR INFORMATION, PLEASE LIST THEM BELOW. THIS IS YOUR AUTHORIZATION FOR PAIN CONSULTANTS OF ALABAMA, COMPREHENSIVE PAIN & REHABILITATION TO DISCUSS AND/OR RELEASE SUCH INFORMATION.

1 _____ 2. _____

3 _____ 4. _____

ASSIGNMENT OF BENEFITS: I hereby assign and authorize payment directly to Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation of all benefits due to me under Medicare, Medicaid, Tricare, or any insurance policy providing benefits for facility charges, for services rendered by Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation. A copy of this agreement shall be considered effective and valid as the original.

FINANCIAL AGREEMENT: In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation and my third party payer, I HEREBY AGREE, WHETHER I AM SIGNING AS THE PATIENT RO GAURANTOR, TO PAY ALL SUMS DUE TO PAIN CONSULTATNS OF ALABAMA, COMPREHENSIVE PAIN & REHABILITATION files for payment for services from my insurer or other payer to make payment shall not relieve me of my obligation to pay Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation.

I understand that it is my responsibility to pay all co-pays, deductibles, and co-insurance payments at the time of service unless financial arrangements are set up in advance.

I further understand that Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation will file any applicable claims as a matter of convenience; it is my responsibility to provide accurate and valid insurance information to Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation. Failure to provide accurate information may result in my responsibility for all charges to my account.

I understand that it is my responsibility to provide a referral from my Primary Care Physician should it be required by the insurance carrier. Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation will allow up to sixty (60) days for the insurance carrier to pay the claim. After sixty (60) days, I understand that the charges for treatment may be transferred to my responsibility. I will be responsible for any unpaid balance by the insurance carrier.

The staff of Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation will provide a monthly statement of charges to my account; I understand that it will be my responsibility to pay the balance in full each month unless other financial arrangements are made.

I understand that should my account become past due and the account sent to an outside Collection Agency, I will be responsible for the account balance, attorney fees, court fees, and any other fees associated with the collection of this account.

I certify that I am the patient or guardian and that I am financially responsible for the services rendered by Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation and do hereby unconditionally guaranty the payment of all amounts when and as due. Pain Consultants of Alabama, Comprehensive Pain & Rehabilitation employees are NOT able to define or interpret your insurance coverage. If you have questions, you are advised to call your insurance company.

_____ _____

SIGNATURE OF PATIENT, GUARANTOR DATE

OR AUTHORIZED PERSON

Comprehensive Pain & Rehabilitation

4105 Hospital Road, Suite 112-A
Pascagoula, MS 39581
228.938.0700 ● 228.938.0705 Fax

230 North Greeno Rd
Fairhope, Al 36532
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PAIN MANAGEMENT AGREEMENT

The purpose of the Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies must be agreed upon by you, the patient, as consideration for, and a condition of, the willingness of the physician to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

I understand that if I break this Agreement, my doctor will stop prescribing these pain control medications. In this case, my doctor will taper off the medication over a period of several days if necessary to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and integrity of my pain, the effect of the pain om my daily life, and how well the medication is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other doctor. I will safeguard my paid medication from loss or theft. Lost or stolen medications will not be replaced. I agree that refills of my prescription pain medication will be made only at the time of any office visit or during regular office hours. No refills will be available during evening hours or on weekends.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy. In the investigation of any possible misuse. Sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive my applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also agree to only use one pharmacy. I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications.

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time. You must understand that ny medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been answered. A copy of this document has been given to me and to the physician from whom I seek treatment.

Pharmacy_____ Telephone_____

Patient Signature_____ Date_____

Comprehensive Pain & Rehabilitation Cancellation/NO Show Policy

Our goal is to provide quality, caring and respectful medical care in a timely manner. In order to do so we have implemented an appointment cancellation/No show policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of Appointment:

In order to be respectful of the medical needs of the community, please be courteous and call the clinic promptly if you are unable to attend your appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of the community.

How to Cancel Your Appointment:

Please call: **Pascagoula/Biloxi Office @ 228-938-0700**

Fairhope/Mobile Office's @ 251-625-2228

If you do not reach the receptionist you may leave a detailed message on the voicemail. Appointments must be cancelled by 10:00 a.m. one (1) working day before scheduled appointment.

Late Cancellation:

Late cancellations will be considered as a "NO SHOW"

No Show Policy:

A no show is someone who misses an appointment without canceling it by 10:00 a.m. one (1) working day in advance. No shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded as a "NO SHOW". An administrative fee for established patients of **$50.00** for medication checks and follow ups, & **$100.00** for procedure appointments**.** If you are a New Patient a **$75.00** fee will be assessed to hold your time slot when rescheduling and will be applied to your next visit/account). **All fees must be collected prior to scheduling another appointment.**

I, _____ have read and understand the **Cancellation/ No Show** policy.

_____ _____

Patient Signature Date

Pain Consultants of Alabama, dba Comprehensive Pain & Rehabilitation
Patient's Rights and Responsibilities

Policy:

As a recipient of Federal financial assistance, Pain Consultants of Alabama, DBA Comprehensive Pain & Rehabilitation treats patients and their caregivers with respect, consideration and dignity and does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of age, race, color, gender, national origin, religion, culture, physical or mental disability, personal values or belief systems or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Pain Consultants of Alabama, DBA Comprehensive Pain & Rehabilitation directly or through a contractor or any other entity with which Pain Consultants of Alabama, DBA Comprehensive Pain & Rehabilitation arranges to carry out its programs and activities. Patients will receive a copy of these rights and responsibilities prior to the date of the procedure.

Each patient has the right to:

1. Receive appropriate care in a safe setting as directed by the physician from staff members who are friendly, considerate, respectful, and qualified to perform the services for which they are responsible with the highest quality of service.
2. Expect appropriate privacy with regard to treatment while in the facility and treatment of all patient health information held by the facility in medical records except when disclosure is required by law.
3. Approve or refuse the release of patient health information except in the case of acute transfer to another facility or when disclosure is otherwise required by law.
4. Complete information, to the extent known by the physician, regarding diagnosis, evaluation, treatment plan, procedure and prognosis, as well as alternative treatments or procedures and the potential risks and side effects associated with treatment plan and procedure.
5. Participate in decisions regarding their healthcare, except when contraindicated for medical reasons. If the patient is unable to participate in such decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
6. Information regarding the scope of services available at the facility and provisions for after-hours emergency care.
7. Information related to fees for services rendered and facility policies regarding payment for such services.
8. Refuse treatment to the extent permitted by law and be informed of the medical consequences of such a refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility..
9. Information regarding and assistance in changing primary or specialty physicians or dentists if other qualified physicians or dentists are available.
10. Request information regarding the credentialing of healthcare professionals who provide care at the facility.
11. Information regarding the absence of malpractice insurance coverage when applicable to the healthcare professional providing patient care.
12. Information regarding the procedure for expressing suggestions and/or grievances and external appeals as required by state and federal regulation.
13. Be free from all forms of abuse or harassment.
14. Exercise his or her rights without being subjected to discrimination or reprisal.

Each patient is responsible for:

1. Provision of complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
2. Following the treatment plan prescribed by his/her provider
3. Assuring that a responsible adult is available to transport him/her home from the facility and remain with him/her for 24 hours if required by his/her provider
4. Informing his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care
5. Accepting personal financial responsibility for any charges not covered by his/her insurance
6. Being respectful of all the health care providers and staff, as well as other patients
7. Respecting the property of others and the facility.
8. Confirmation of whether he or she clearly understands the planned course of treatment.
9. Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.

We pledge that each patient will receive the highest patient care available, delivered in a professional, friendly and confidential manner. Comments or concerns regarding our service may be made directly to our Administrator, **Rhonda Rogers**, or you may contact us by telephone, US Mail or email using the following contact information.

Pain Consultants of Alabama, DBA Comprehensive Pain & Rehabilitation

Alabama Office
230 North Greeno Rd
Fairhope, Al 36532
251-625-2228
rrogers@nopaindr.com

-OR-

Mississippi Office
4105 Hospital Road, Ste: 112B
Pascagoula, MS 39581
228-938-0700
rrogers@nopaindr.com

You may also contact the **Alabama** State Department of Health or go to the Office of the Medicare Beneficiary Ombudsman website to report a specific grievance associated with your care at this facility.

Alabama State Department of Health-Central Office

Alabama Information & Quality Healthcare (IQH)

Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/claims-and-appeals/file-a-complaint/complaints.html

Our Mississippi patients
You may also contact the **Mississippi** State Department of Health or go to the Office of the Medicare Beneficiary Ombudsman website to report a specific grievance associated with your care at this facility.

Mississippi State Department of Health-Central Office
570 East Woodrow Wilson Drive
Jackson, MS 39216
601-576-7400

Mississippi Information & Quality Healthcare (IQH)
385 B Highland Colony Parkway, Suite 504
Ridgeland, MS 39157
Patient Grievance Line: 866-775-5897

Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Patient's Rights and Responsibilities:

Above is a listing of Pain Consultants of Al Patient's Rights and Responsibilities. You are responsible for reviewing this document and referring any questions to Pain Consultants of Alabama Daphne office at 251-625-2228, or our Mississippi office at 228-938-0700

Physician Ownership:

Please note that your physician may have a financial interest in Pain Consultants of Alabama, DBA Comprehensive Pain & Rehabilitation. The current physician owner(s) at Pain Consultants of Alabama, DBA, Comprehensive Pain & Rehabilitation, include:

Hunting Hapworth, MD
Matthew Barfield, DO
Joshua Tucker, DO

Pain Consultants of Alabama, dba

Comprehensive Pain & Rehabilitation

Effective Date

This notice is effective April 14, 2004 and Revised on January 20, 2017.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

_____ _____/_____/_____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe the relationship to the patient:

_____

_____

_____

Primary area of pain: _____
Secondary area of pain: _____

Onset:

- o Chronic pain
- o New onset pain
- o Sudden onset pain
- o Gradual onset pain

- o Accident at work
- o Following a motor vehicle accident
- o Home accident
- o Recent illness or injury
- o Recent surgery
- o fall
- o unknown

Describe your pain: (Please check all that apply)

- o Aching
- o Shooting
- o Sharp
- o Burning
- o Stinging
- o Electrical
- o Penetrating
- o Numbing
- o Unbearable
- o Throbbing
- o Stabbing
- o Tender
- o Nagging
- o Miserable
- o Spasms

Pain Travels:

Neck:

- o Down both arms
- o Down right arm
- o Down left arm

Back:

- o Down both legs
- o Down right leg
- o Down left leg

Pain Associated with: (Please check all that apply)

- o Bowel urgency
- o Bladder
- o Bilateral calf pain worse with walking
- o muscle spasms
- o limb swelling
- o tingling
- o numbness
- o numbness in right arm
- o numbness in left arm
- o numbness in both arms
- o numbness in right hand
- o numbness in left hand
- o numbness in both hands
- o numbness in right leg
- o numbness in left leg
- o numbness in both legs
- o localized skin discoloration
- o excessive sweating
- o feelings of weakness
- o sudden onset of cold extremities

Pain is worse with: _____

Pain is better with: _____

Previous treatments for pain: (Please check all that apply)

- o home excerise
- o nonsteroidal anit-inflammatory
- o injections
- o physical therapy
- o surgery
- o chiropractic therapy
- o psychotherapy

Functional/Occupational Limitations: During the past month, mark activities you avoid because of pain

- o going to work
- o performing household chores
- o caring for self
- o having sexual relations
- o socializing with friends
- o participation in recreation
- o physically exercising
- o other _____

Have you had to stop working or change work related activities? ____ Yes ____ No

Have you filed any legal claims related to your pain problems? ____Yes ____No Does your pain keep you up at night? ____Yes ____No

Past Medical History: (Please check all that apply)

- o headache
- o taking anticoagulants
- o coronary artery disease
- o congestive heart failure
- o hypertension
- o COPD
- o sleep apnea
- o esophageal reflux
- o gastric ulcer
- o cholecystitis
- o chronic liver disease
- o chronic kidney disease
- o nephrolithiasis
- o hyperlipidemia
- o thyroid disorder
- o hypothyroidism
- o hyperthyroidism
- o osteoporosis
- o diabetes mellitus
- o gout
- o migraine headaches
- o TIA
- o CVA
- o dementia
- o hematologic disorder
- o cancer
- o anxiety
- o depression
- o shingles
- o HIV/AIDS
- o hepatitis
- o bleeding disorder

Surgical History: (Please check all that apply)

- ○ Neck
- ○ Back
- ○ Tonsillectomy
- ○ Heart surgery
- ○ Mastectomy
- ○ Splenectomy
- ○ Appendectomy
- ○ Hemorrhoidectomy
- ○ Cholecystectomy
- ○ Hernia repair
- ○ Hysterectomy
- ○ Cesarean section
- ○ Vasectomy
- ○ Prostatectomy
- ○ Hip surgery
- ○ Knee surgery
- ○ Hemi laminectomy

Family History:

- ○ Cancer
- ○ Heart disease
- ○ Systemic HTN
- ○ Diabetes
- ○ Stroke

Social History:

What is your relationship status?

	Single		**Married**		**Separated**		**Divorced**		**Widowed**

What city do you live in? _____ Who do you live with? _____

Yes	**No**	**Please check yes or no to the following questions:**
		Do you smoke?
		If yes, how much?
		If you quit, how long ago was that?
		Do you use other nicotine products?
		Have you ever been in a detoxification program for drug abuse?
		Have you ever been treated at a Methadone clinic?
		Have you ever abused pain, sleep, anxiety, cold, psychiatric, diet, or any other prescription medication?
		Has a parent, sibling or child abused alcohol or been diagnosed with alcoholism?
		Has a parent, sibling or child used illegal drugs?
		Has a parent, sibling, or child ever abused pain, sleep, anxiety, cold, psychiatric, diet or any other prescription medications?
		Does anyone sharing the home take prescription pain medications?
		Does anyone sharing the home abuse, misuse, or sell prescription or illicit drugs?
		Do you suffer from physical abuse or safety hazards in your current living situation?
		If yes, please explain:
		Do you have a history of physical or emotional abuse?
		Were you a victim of childhood sexual abuse?
		Have you used drugs other that those required for medical reasons?
		Do you abuse more than one drug at one time?
		Are you always able to stop using drugs when you want to? **(If you never use drugs answer Yes)**
		Have you had “blackouts” or “flashbacks” as a result of drug use?
		Do you ever feel bad or guilty about your drug use? **(If you never use drugs, answer No)**
		Does your spouse (or parents) ever complain about your involvement with drugs?
		Have you neglected your family because of drugs?
		Have you engaged in illegal activities in order to obtain drugs?
		Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking your drugs?
		Have you ever had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, bleeding, etc)?

Psychological History: Please check Yes or No to the following:

Yes	**No**	
		Have you ever accidentally overdosed on medications?
		Have you ever attempted suicide?
		If yes, did the attempted suicide involve intentional overdose on medications?
		Do you have suicidal thoughts?
		Have you ever been hospitalized for psychiatric issues?
		Are you currently under the care of a psychiatrist? **Who?**
		Have you been diagnosed with or suffer from Attention deficit disorder (ADD)?
		Have you been diagnosed with Obsessive compulsive disorder (OCD)?

		Continued Psychological History: Please check Yes or No to the following
Yes	**No**	
		Have you been diagnosed with Bipolar disorder?
		Have you been diagnosed with Schizophrenia?
		Have you been diagnosed with Post Traumatic Stress Disorder (PTSD)?
		Have you been diagnosed with Borderline personality disorder?
		Have you been diagnosed with or suffer from Anxiety?
		Have you been diagnosed with or suffer from depression?

Please mark the most appropriate answer to the following questions

Over the past 2 Weeks, how often have you been bothered by any of the Following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly Every Day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or-that you're a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper, or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or, the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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

	Not difficult at all		Somewhat difficult		Very difficult		Extremely difficult

Review of systems: Please mark all that apply to your health

- o Chest pain
- o Fever
- o Nasal discharge
- o Vision changes
- o Sore throat
- o Cough
- o Wheezing
- o Unintentional weigh gain
- o Rash
- o Nausea
- o Shortness of breath
- o Bowel incontinence
- o Diarrhea
- o Numbness
- o Unintentional weight loss
- o Extremity swelling (arms,hands,legs)
- o Weakness
- o Urinary incontinence
- o Altered mental status
- o Constipation
- o Gastric upset/discomfort
- o Hives
- o Confusion

Please list all the Physicians that are currently treating you:

Name	Specialty	Location

Allergies: Please list all the allergies you currently have including vitamins/herbs/supplements/latex/contrast dye

Medication Name	Reaction

Medications: Please list all the medications you currently take including vitamins/herbs/supplements.

Medication Name	Dose (mg, mcg, etc)	Route taken (by mouth, injected, etc)	Frequency (once, twice, three times daily)

Use additional paper if necessary