

WEST COAST  
CENTER FOR  
ORTHOPEDIC  
SURGERY  
AND SPORTS  
MEDICINE  
MANHATTAN BEACH CA

# PATIENT INFORMATION

(PLEASE PRINT CLEARLY)

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOC. SEC.# \_\_\_\_\_ DRIVERS LIC# \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Number & street city state zip

E-MAIL ADDRESS \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

PATIENTS/GUARANTOR'S EMPLOYER \_\_\_\_\_ PHONE # \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_  
Number & street city state zip

EMERGENCY CONTACT: \_\_\_\_\_ PHONE # \_\_\_\_\_

HOW WERE YOU REFERRED TO OUR OFFICE \_\_\_\_\_

## INSURANCE INFORMATION (PLEASE LET US COPY YOUR INS. CARDS)

### PRIMARY INSURANCE:

INS. CO. NAME \_\_\_\_\_

INSURED ID# \_\_\_\_\_

GROUP# \_\_\_\_\_

INSURED NAME \_\_\_\_\_

INS. CO. PHONE# \_\_\_\_\_

### PATIENT'S RELATIONSHIP TO INSURED

SELF  SPOUSE  CHILD  OTHER

### SECONDARY INSURANCE:

INS. CO. NAME \_\_\_\_\_

INSURED ID# \_\_\_\_\_

GROUP# \_\_\_\_\_

INSURED NAME \_\_\_\_\_

INS. CO. PHONE# \_\_\_\_\_

### PATIENTS RELATIONSHIP TO INSURED

SELF  SPOUSE  CHILD  OTHER

## ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other plan to *KEITH S. FEDER, MD*. I hereby authorize/consent to treatment, by Keith S. Feder, MD and Associates. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I also understand that should legal action be necessary to collect any unpaid balance due for medical services rendered I will be held responsible for all attorneys' fees and other costs of collection to the full extent permitted by law. I hereby authorize said assignee to release information necessary to secure payment. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date

**WEST COAST CENTER FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE**

**FINANCIAL POLICY**

We appreciate the opportunity of participating in your medical care. Your health is our concern. Our financial policy as set forth below is designed to allow us to offer the best medical care to all of our patients. With this in mind, we thank you in advance for adhering to the following terms.

The usual charge for an initial comprehensive examination is \$750.00. Thereafter, a copayment and/or a percentage payable, as stated by your insurance policy, will be expected at the time of each visit. If you have not met your deductible however, then payment in full will be expected until your deductible is met. Thereafter your copayment/percentage will apply. If your insurance company refuses to divulge your deductible status, we will assume your deductible is not met unless you provide us with written proof that it is met, such as a copy of an explanation of benefits.

As a courtesy to you, we will bill your insurance company at no charge. However, we do ask that you provide complete and accurate insurance information as requested on the Patient Information sheet, which you complete at your first visit. It is your responsibility to update us regarding any change in that information and we may periodically ask you to complete a new form.

Once payment is received from your insurance company, we will bill you for any remaining balance due. If the insurance payment results in a credit balance and you are still receiving treatment, it will be applied to your account. If you have completed treatment, a refund check will be mailed to you.

If we experience undue delay in payment by your insurance company (beyond 45 days from the date of submission) we may ask you for full or partial payment and/or ask that you promptly follow-up with your insurance company to obtain expedited payment. If you have secondary insurance coverage, we will also bill them for you for the balance due after your primary insurance has paid.

If you are involved in an automobile accident and have "med pay" coverage, we will bill them directly until benefits have been exhausted. We can then bill your private health insurance for any dates not exceeding one year from time of submission or you can continue on a cash basis.

Please understand that your insurance coverage involves a contract between you/your employer and the insurance company and we are not a party to that agreement. West Coast renders service directly to you. Therefore, regardless of any insurance coverage (except Workers Compensation & Training to Win), you are personally responsible for all charges.

For your convenience we accept payment by cash, check or credit card.

If you are unable to meet these terms, or if you have any questions, please contact me at (310) 416-9700 to make other arrangements or have your questions answered. You will be asked to sign a financial agreement reflecting any special terms we agree upon.

Please sign and date below to indicate that you understand and agree to the foregoing terms.

Sincerely,

**WEST COAST CENTER/KEITH S. FEDER, MD INC.**

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**SIGNATURE**

---

**DATE**

**West Coast Center for Orthopedic Surgery & Sports Medicine**  
**Release-Authorization-Assignment of Benefits**

**Consent to Treatment**

I, the undersigned patient, agent for the patient, or legal guardian, consent to the procedures which may be performed on me during my visits to this office. I authorize **West Coast Center for Orthopedic Surgery and Sports Medicine** and its physicians, fellows, visiting residents, and/or technicians to perform on me any and all required and all required treatments and/or procedures, including but not limited to emergency treatment and services, laboratory procedures, minor surgeries, physical examinations, x-rays, injections, ultrasound guided injections, EMG/NCV studies, Ultrasound studies, or physical therapy sessions. I agree that if I discontinue medical care at this office contrary to the opinion or decision of this physician, I will hereby relieve this office, physicians, and associates of all responsibilities for my health.

**Release of information**

I, the undersigned patient, agent for the patient, or legal guardian, agree that the **West Coast Center for Orthopedic Surgery and Sports Medicine** and associates may disclose and/or release a portion or all of the patients record including his/her medical record, to any person or entity which is or may be responsible for all or any portion of the office and/or physician's charges.

In considering the amount of medical expenses to be incurred, I, the undersigned patient, agent for the patient, or legal guardian, have insurance, health insurance, and/or employee health care benefits coverage with the above captioned and/or has healthcare benefits/insurance/health insurance per the information provided, and hereby assign and convey directly to The West Coast Center for Orthopedic Surgery/Keith S. Feder MD Inc., Carol Frey, MD, Inc., associates, and healthcare provider(s), **as my designated Authorized Representatives**, ALL medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. **I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA.**

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my providers/in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

**APPENDUM TO PATIENT FINANCIAL RESPONSIBILITY**

I acknowledge the possibility that a check and or checks may be sent directly to me instead of you, my provider. I understand this money is not mine even though the check may be written to me. I understand you are billing my insurance company as a courtesy to me, but the money paid by the insurance company belongs entirely to you. I therefore, agree to immediately, but certainly no later than 48 hours upon receipt of any such monies, forward this money directly to you. I will make no attempt to negotiate what portion I send to you. In any event, I acknowledge and

agree that I am legally responsible for any charges for service rendered to me and I will pay all fees including any co-pays or deductibles, if applicable.

**NOTE:** Please read the above agreements carefully and make sure that you understand all the items and conditions before signing below. If you do not understand, please review contents with the staff prior to signing. Your signature confirms that you have read and fully understand all the agreements, terms, and conditions above.

**Authorization for the Release of Medical Records**

I, the undersigned patient, agent for the patient, or legal guardian, hereby grant permissions to and authorize any physicians, medical practitioner, hospital, pharmacy, clinic, or other medical or medically-related facility or provider of medical or dental services or supplies, any employer, insurance or reinsurance companies, benefits plan administrator, educational institutions, or any federal, state or local government agencies, including social security administration, veteran administration, and/or entities release my complete medical records in their possession to **West Coast Center for Orthopedic Surgery and Sports Medicine** and/or its physicians. A photocopy or facsimile of this authorization shall be valid and effective as the original.

**Medicare Patients Release of Information**

I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made directly to this physician and/or medical group and I understand that I am responsible for the remaining balance not covered by other insurance.

**Notice of Privacy Practice- HIPAA Compliance**

This facility is HIPAA compliant. The patient's privacy is protected including medical and personal information. As required by law, we will use and disclose our patient's health information in a limited way according to the requirements by all applicable laws, I, the undersigned patient, agent for the patient, or legal guardian, have been informed of my privacy rights.

**Patient's Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Relationship to patient** \_\_\_\_\_

**Date** \_\_\_\_\_

**West Coast Center for Orthopedic Surgery and Sports Medicine**



ORTHOPÆDIC  
FOOT AND ANKLE  
SPECIALIST

RE: Cancellation of PPO/EPO Contracts

Dear Patient:

Effective immediately our office does **not** participate with any Insurance plans. This became necessary due to the unreasonably low contract payments forced upon us by these plans.

**Blue Shield and Blue Cross will send payments directly to you. Please deposit checks and either pay the doctor with a check or credit card and include the Explanation of Benefits (EOB'S) with payment.**

**We will bill your insurance companies as an out-of-network provider on your behalf.**

**Any questions regarding your insurance company should be directed to our billing staff at time of service.**

Thank you for your cooperation and understanding.

Sincerely,

***Dr. Feder & Dr. Frey***

I have read and understand the above information.

---

Signature

Date

---

Print Patient Name

**Keith S. Feder, M.D. & Carol Frey, M.D.**

1200 Rosecrans Ave #208, Manhattan Beach, CA. 90266

310-416-9700 [www.westcoastorthopedics.com](http://www.westcoastorthopedics.com)

**Keith S. Feder, M.D.**  
*West Coast Center for  
Orthopedic Surgery  
and Sports Medicine*



**Carol Frey, M.D.**  
*Orthopedic Foot &  
Ankle Center*

## **POLICY FOR SUPPLIES**

Because there is no guarantee that your insurance company will pay for the supplies that the doctor has ordered for you, we have made the following two options available to you, our patient.

- 1) The doctor requests that all supplies are paid for at the time the patient receives the item. You have the option of paying for the supplies at the time of your visit. **(or)**
- 2) You can wait until we submit a claim to your insurance carrier to request payment for the supplies needed. This may take up to 60 days or more to get a response from your insurance company. If you decide on this option, you will not receive any supplies until your insurance company pays us in full for the supplies, unless the doctor has made prior arrangements with you, the patient.

With either option, you will be responsible for any remaining balance that your insurance company does not pay. If your insurance company pays 100% then your deposit will be applied to any unpaid balance due on your account. If you do not have any unpaid balance on your account, your account will be credited, the balance will be used toward any further services rendered. If you do not have any unpaid balances a refund check will be issued, if requested by the patient.

### **PLEASE NOTE:**

- 1) You will be responsible for any attempts or inquiries to your insurance company, regarding processing of this claim for payment. Professional services are rendered to you, our patient, not to your insurance company. Which means the insurance company is responsible to you directly.
- 2) All supplies are non-returnable once they leave our office for health and safety reasons.

**Thank you for your understanding and cooperation.**

**PRINT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

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

**WITNESS:** \_\_\_\_\_

**Member Authorization Form for a Designated Representative to Appeal a Determination**

**Date:** \_\_\_\_\_

**Member Name:** \_\_\_\_\_

**Member Number:** \_\_\_\_\_

I hereby authorize Keith Feder M.D., Carol Frey M.D., West Coast Center for Orthopedic Surgery and Sports Medicine and Associates to appeal determination concerning:

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

on my behalf, as my Designated Representative, and as part of the appeal I hereby authorize in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for vernal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in the authorization, or as required or permitted by law. This authorization is valid for a period of one year.

x \_\_\_\_\_  
**Signature of Member or Legal Guardian/Representative**

x \_\_\_\_\_  
**\_\_Signature of Witness                      \_\_Designated Representative (check one)**

x \_\_\_\_\_  
**Name of Witness/ Designated Representative (Please Print)**

x \_\_\_\_\_  
**Title (if on provider's staff of relationship of Member)**



## MEDICAL HISTORY SCREENING FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referred by: \_\_\_\_\_

Primary care physician/Internist: \_\_\_\_\_ Orthopedic surgeon: \_\_\_\_\_

Pharmacy Name & Address: \_\_\_\_\_

### **MARITAL STATUS:**

Married  Divorced  Separated  Single  Widow/Widower

### **LIVES WITH: (SOCIAL HISTORY):**

Alone  Spouse  Family  Friends  Nursing Home  Retirement Home  Other: \_\_\_\_\_

### **WORK STATUS (SOCIAL HISTORY):**

Occupation: \_\_\_\_\_ Last date worked? \_\_\_\_\_ or  N/A

Not currently working  Currently working  Disabled If yes, how? \_\_\_\_\_  Retired  Unemployed

Work w/ restrictions  yes  no If yes, details please. \_\_\_\_\_

Left-handed  Right-handed  Ambidextrous

### **PERSONAL HABITS:**

Cigarettes:  No  Yes pks/day \_\_\_\_\_ or cig/day \_\_\_\_\_ Alcohol:  No  Yes If yes, how much?  Often  socially  Occasionally  Rarely

Chew tobacco :  No  Yes, How many times a day? \_\_\_\_\_ Pipe:  No  Yes # cigars/day \_\_\_\_\_

Illegal Drug use:  No  Yes, If yes, drug name \_\_\_\_\_

Over the counter medications \_\_\_\_\_

Vitamins \_\_\_\_\_

### **HISTORY OF PRESENT ILLNESS/INJURY:**

Reason for visit/ Injured Body Part/Injury? \_\_\_\_\_

How and when did the problem start? \_\_\_\_\_

### **EVALUATION OF PAIN/DISCOMFORT:**

What activities are you unable to do because of the pain? \_\_\_\_\_

Does the pain keep you awake at night?  No  Yes If yes, please give details. \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

What makes it feel worse? \_\_\_\_\_

**Pain scale (circle one number) No Pain 1 2 (mild) 3 4 5 6 7 8 (moderate) 9 10 Severe pain (severe)**



PATIENT NAME: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PREVIOUS TREATMENT FOR THIS PROBLEM:**

What other physicians have you seen for this problem: \_\_\_\_\_

What prescriptions are you using presently? \_\_\_\_\_

Any physical therapy?  No  Yes If yes, name and date: \_\_\_\_\_

Any chiropractic care?  No  Yes If yes, name and date: \_\_\_\_\_

Other treatments? \_\_\_\_\_

Use of assistive devices for this problem?  Cane  Splints  Braces  Walker  Other: \_\_\_\_\_

Is this being covered by Workmen's Compensation?  No  Yes Date of Injury: \_\_\_\_\_

Is this being covered by Auto Insurance (MedPay)?  No  Yes Date of Injury: \_\_\_\_\_

Is there a lawsuit or litigation pending in regard to your injury?  No  Yes

Attorney Name: \_\_\_\_\_

Address: \_\_\_\_\_

**PAST MEDICAL HISTORY:** (Please check all that apply. If you do not have anything to mark or add please select NONE)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV                               | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Prostate Disease     |
| <input type="checkbox"/> Bladder Disease                        | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bleeding Disorder                      | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Seizure Disorder    | <input type="checkbox"/> Blood Clots (DVT)    |
| <input type="checkbox"/> Heart Attack                           | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Stomach Ulcers      | <input type="checkbox"/> Bronchitis           |
| <input type="checkbox"/> Heart Disease                          | <input type="checkbox"/> Lung Disease             | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Heart Murmur         |
| <input type="checkbox"/> Cancer If so, where? _____             | <input type="checkbox"/> Multiple Sclerosis (MS)  | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Currently Pregnant   |
| <input type="checkbox"/> Parkinson's Disease                    | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Osteoarthritis      | <input type="checkbox"/> Vascular Disease     |
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Hodgkin's Disease        | <input type="checkbox"/> Osteoporosis        | (circulation)                                 |
| <input type="checkbox"/> Fibromyalgia                           | <input type="checkbox"/> Hypertension (High BP)   | <input type="checkbox"/> Parathyroidism      | <input type="checkbox"/> Other (describe):    |
| <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Hyperthyroidism          |  | _____   |
- NONE**

**ANY** current infections, open sores or open wounds?  No  Yes, If so, where? \_\_\_\_\_

**PRIOR SURGERIES:** (Please mark all that apply. If there are no prior surgeries, please select NONE)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Appendectomy                        | <input type="checkbox"/> D&C (Dilation & Curettage) | <input type="checkbox"/> Pacemaker Insertion    |
| <input type="checkbox"/> Arthroscopy: If so, where? _____    | <input type="checkbox"/> Endoscopy                  | <input type="checkbox"/> Rotator Cuff Repair    |
| <input type="checkbox"/> Ankle Repair                        | <input type="checkbox"/> Gastric Bypass             | <input type="checkbox"/> ACL Repair             |
| <input type="checkbox"/> Carpal Tunnel Release               | <input type="checkbox"/> Bicep Tendon Repair        | <input type="checkbox"/> Shoulder Repair        |
| <input type="checkbox"/> Meniscectomy                        | <input type="checkbox"/> Hernia Repair              | <input type="checkbox"/> Stent Placement        |
| <input type="checkbox"/> Labrum Repair                       | <input type="checkbox"/> Knee Replacement           | <input type="checkbox"/> Achilles Tendon Repair |
| <input type="checkbox"/> Cholecystectomy (gallbladder)       | <input type="checkbox"/> Hip Replacement            | <input type="checkbox"/> Scope Subtalar         |
| <input type="checkbox"/> Colonoscopy                         | <input type="checkbox"/> Wrist Repair               | <input type="checkbox"/> Peroneal Tendon Repair |
| <input type="checkbox"/> Coronary Artery Bypass Graft (CABG) | <input type="checkbox"/> Laminectomy                | <input type="checkbox"/> Other: _____           |
- NONE**

If any of the above have been marked please provide the date of surgery (s): \_\_\_\_\_

**PRIOR FRACTURES:** (Please write down what fractures you have had in the past. If there are NOT any fractures, please select NONE)

\_\_\_\_\_

**NONE**

PATIENT NAME: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**FAMILY HISTORY:** (Please mark all that apply. If you have nothing to select or add, please select NONE)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bleeding Disorder          | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Cancer: If so, where? ____ | <input type="checkbox"/> Musculoskeletal Disease | <input type="checkbox"/> Thyroid Disease  |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Osteoarthritis          | <input type="checkbox"/> Hypertension     |
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Other: _____               |  |   |

NONE

**REVIEW OF SYSTEMS:** (Please mark all that apply. Mark NONE under EACH section if no symptoms are selected):

**Constitutional:**

- Anorexia
- Anxiety
- Body aches
- Fainting
- Fever
- Fatigue
- Fever
- Loss of appetite
- Seizures
- Sweats
- NONE

Comments: \_\_\_\_\_

**Ears, Nose, Mouth & Throat (ENMT):**

- Allergies
- Obstructed Breathing
- Bloody Nose
- Polyps
- Congestion
- Sinus Pain
- Frequent Colds
- Frequent Colds
- Stuffy Nose
- Mouth Breathing
- Ulcers
- NONE

Comments: \_\_\_\_\_

**Cardiovascular (CV):**

- Angina
- Breathing, painful
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Chest pain
- Chest discomfort
- Chest tightness
- Dizziness
- Dyspnea (difficulty breathing)
- High blood pressure
- Irregular heartbeat
- Palpitations
- Shortness of breath (SOB)
- NONE

Comments: \_\_\_\_\_

**Respiratory:**

- Bronchitis
- Respiratory Disease
- Emphysema
- Tuberculosis
- Pneumonia
- Wheezing
- Sleep apnea
- NONE

Comments: \_\_\_\_\_

**Gastrointestinal (GI):**

- Abdominal pain
- Abdominal swelling
- Bloody stools
- Bloody stools
- Bowel movement, painful
- Colon cancer, family history
- Constipation
- Diarrhea
- Gas/bloating
- GERD (gastroesophageal reflux disease)
- Heartburn
- Hemorrhoids
- IBS (irritable bowel syndrome)
- Indigestion
- Nausea
- Ulcer disease
- Urinary incontinence
- Vomiting
- NONE

Comments: \_\_\_\_\_

**Genitourinary (GU):** \_\_\_\_\_

- Bladder infection
- Burning with urination
- Frequency
- Kidney disease
- Kidney stones
- Retention
- Urgency
- UTI (urinary tract infection) frequency: \_\_\_\_\_
- NONE

Comments: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**REVIEW OF SYSTEMS** continued: (Please mark all that apply. Mark **NONE** under EACH section if no symptoms are selected)

**Musculoskeletal:**

- Ambulatory dysfunction
- Arthritis
- Back pain
- Back stiffness
- Balance, (poor)
- Deformities
- Fibromyalgia
- Gout
- Herniated disc
- Joint pain
- Joint, red and hot
- Joint stiffness
- Leg swelling
- Numbness
- Paresthesia
- Rheumatoid arthritis
- Varicose veins
- Tremors
- NONE**

Comments: \_\_\_\_\_

**Hematologic/Lymphatic:**

- Bleeding/clotting disorder
- Blood disease
- Sickle cell anemia
- Easy bleeding
- Easy bruising
- Radiation treatment of any kind
- NONE**

Comments: \_\_\_\_\_

**Skin:**

- Basal cell carcinoma
- Birthmarks
- Bruising
- Eczema
- Latex allergy
- Sneezing
- Rash/Rashes
- Raynaud's
- Shingles
- Sores
- Squamous cell carcinoma
- Tattoo
- NONE**

Comments: \_\_\_\_\_

**Nails:**

- Cracking
- Peeling
- NONE**

Comments: \_\_\_\_\_

**Neurological:**

- Amnesia
- CVA (cerebrovascular accident)
- Blackout
- CVA (cerebrovascular accident)
- Depression
- Disorientation
- Dizziness
- Epilepsy
- Multiple Sclerosis
- Paralysis
- Stroke
- TIA (transient ischemic attack)
- NONE** Comments: \_\_\_\_\_

**Psychiatric:**

- Anxiety
- Crying frequently
- Insomnia
- Memory loss
- Mood changes
- OCD
- Psychiatric treatment
- NONE**

Comments: \_\_\_\_\_

**Allergy/Immunologic:**

- Allergies If yes, What: \_\_\_\_\_
- Food allergy
- Nasal
- Asthma
- Chills
- Coughing
- Diarrhea
- Difficulty breathing
- Difficulty swallowing
- Fever
- Hives
- Itchy skin
- NONE**

Comments: \_\_\_\_\_

**Hair:**

- Alopecia(loss of hair)
- Increased hair growth
- NONE**

Comments: \_\_\_\_\_

**LOCATION OF PAIN**

Draw location of your pain in body outlines below and indicate how bad it is by putting the number from 1 to 10 in the area of the pain. (1 being mild and 10 being extreme)

**INDICATE CONDITION IN THE APPROPRIATE AREAS ON THE DIAGRAM**

**ACHE**

\*\*\*\*\*

**BURNING**

^^^^^

**NUMBNESS**

+++++

**PINS & NEEDLES**

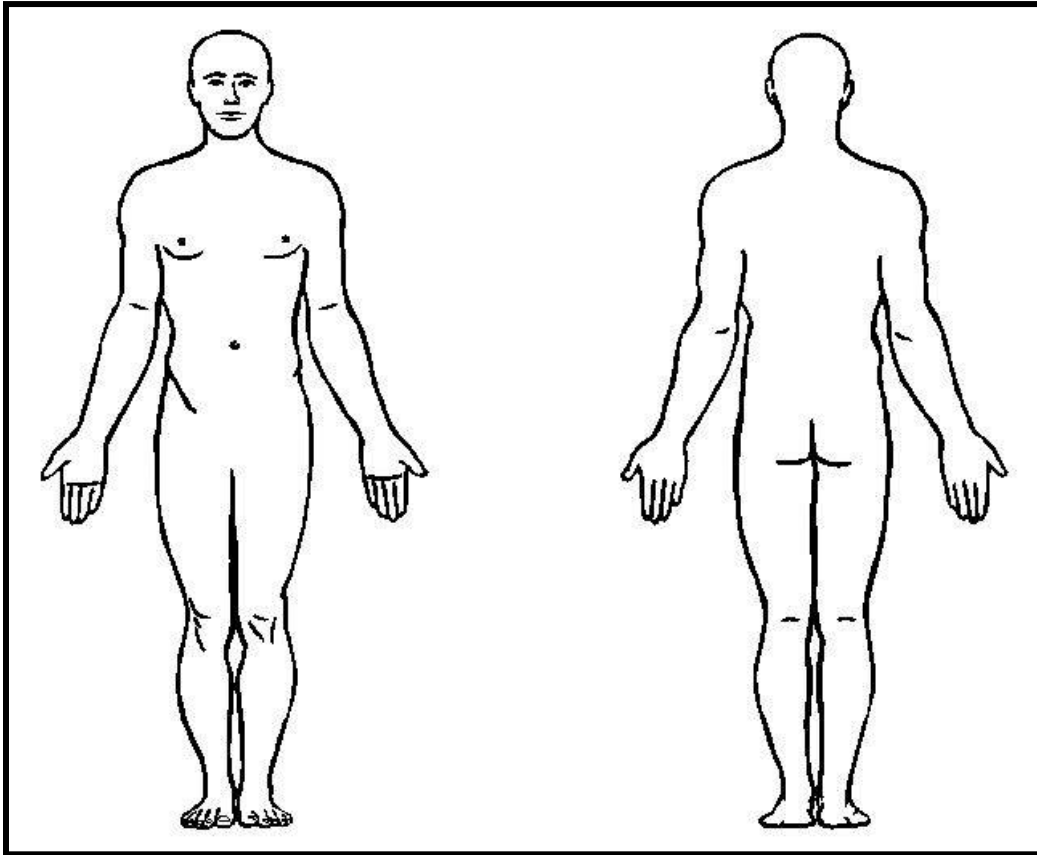
#####

**STABBING**

////

**OTHER**

xxxxx



**FRONT**

**BACK**

Has your condition been aggravated or is there a new condition?  Yes  No

Please explain \_\_\_\_\_

\_\_\_\_\_

What feels better today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date