ADULT PATIENT INFORMATION

Date: ______ / ______ / ______

Patient Name – First: ______________________________ **MI:** ________ **Last:** ________________________________ **SS#** ______ - ______ - ______

DOB: _____ / _____ / ______ **Sex:** ☐ M ☐ F **Race:** ☐ White ☐ AA ☐ Asian ☐ American Indian / Alaska Native ☐ Native Hawaiian / Pacific Islander ☐ Declined

Ethnicity: ☐ Not Hispanic / Latino ☐ Hispanic / Latino ☐ Declined **Preferred Language:** ☐ English ☐ Spanish ☐ Other ________________________

Address: ____ **Apt:** _______ **City:** ___________________________ **St:** _______ **Zip:** __________

Patient Phone – Home: _____________________________ **Cell:** _________________________________ **Work:** ____________________________

Email: ____ **Employer:** ____

Marital Status: ☐ Single ☐ Married ☐ Life Partner **Spouse / Partner's Name:** ____________________________ **Phone:** ______________________

FINANCIALLY RESPONSIBLE PARTY (if different than above)

Name – First: ________________________ **MI:** ______ **Last:** ______________________________ **Relationship to Patient:** ___________________

Address: ____ **Apt:** _______ **City:** ___________________________ **St:** _______ **Zip:** __________

Phone – Home: ________________________________ **Cell:** ___________________________________ **Work:** ____________________________

Email: ____ **Employer:** ____

INSURANCE INFORMATION

Primary Insurance: _________________________________ **ID:** ____ **Group:** ____________________

Policy Holder Name: ____ **Relationship:** ☐ Self ☐ Spouse ☐ Parent ☐ Other ________________

Policy Holder SS# ______ - ______ - _______ **Policy Holder's DOB**: ____ / ____ / _____ **Employer**: _____________________________________

Secondary Insurance: _________________________________ **ID:** ____ **Group:** ____________________

Policy Holder Name: ____ **Relationship:** ☐ Self ☐ Spouse ☐ Parent ☐ Other ________________

Policy Holder SS# ______ - ______ - _______ **Policy Holder's DOB**: ____ / ____ / _____ **Employer**: _____________________________________

EMERGENCY CONTACTS

Name: ____ **Relationship to Patient:** _____________________________________

Phone – Home: ________________________________ **Cell:** ___________________________________ **Work:** ____________________________

Name: ____ **Relationship to Patient:** _____________________________________

Phone – Home: ________________________________ **Cell:** ___________________________________ **Work:** ____________________________

Please provide a copy of all Insurance Cards.

Return completed paperwork and a copy of all insurance cards (including pharmacy benefit card, if applicable) to Bray Family Medicine or send it via email to *registration@brayfamilymed.com* or via fax to (870) 464 – 1514.

Bray Family Medicine Clinic Policies

Thank you for choosing us! The providers & staff at Bray Family Medicine are committed to providing you with the best possible care. Our mission is to improve and deliver healthcare and overall well-being to the people of the community with superior patient service in a peaceful, warm environment. Your clear understanding of our policies is important to our professional relationship. For more information about Bray Family Medicine, visit www.brayfamilymed.com.

	Business Hours	Special Hours	Holidays
Monday	8 AM – 5 PM		New Year's Day
Tuesday	8 AM – 5 PM		Memorial Day
Wednesday	8 AM – 5 PM		Fourth of July
Thursday	8 AM – 5 PM		Labor Day
Friday	8 AM – 5 PM	Closed: 12 – 1 PM for staff meeting	Thanksgiving
			Christmas

Appointments: To schedule an appointment with a medical provider or counselor, call (870) 464-1515. We strive to stay on time, but due to unforeseen circumstances, an appointment may take longer than allotted. You will be informed of any delays. Please notify the front desk if you are still in the waiting room 30 minutes after your scheduled appointment time.

Cancellations / Missed Appointments: If you cannot keep an appointment, please call within 24 hours of your scheduled appointment time so that we can offer that time to another patient in need of care. If you do not cancel within 24 hours of your appointment time, you will be charged a no-show fee of $30. This fee must be paid in full before your next office visit. Bray Family Medicine may choose not to see those who repeatedly miss appointments or cancel appointments without sufficient notice. Being hospitalized or providing an explanation regarding an emergent event or circumstance beyond your control will not be considered a no-show.

Refill Requests: To request a prescription refill, please contact your pharmacy directly. If you have no refills remaining, your pharmacy will send a refill request electronically allowing us to respond quickly. Refill requests are processed during regular business hours usually on the same day we receive the request. If your refill is not ready within 48 hours, call us at (870) 464 – 1515. Please check your medications before all vacations, holidays and weekends to ensure you have an ample supply during these times.

Contact Your Care Team: If the situation requires urgent attention, call us at (870) 464 – 1515 and relate the urgency to our operator. **In an emergency, dial 9-1-1**. Non-urgent questions and requests can be made by:

- texting us at **(870) 466 – 4624**,
- sending a secure message through the **Patient Portal**,
- emailing us at caremanager@brayfamilymed.com or
- calling us at (870) 464 – 1515 and leaving a voicemail including your full name, date of birth and detailed message.

Urgent After-Hours Care: A member of your care team can be reached after-hours by calling (870) 464 – 1515. Follow the prompts so that the on-call provider and staff will receive your message and can access important medical information. If you experience a critical situation, go immediately to the emergency department of the hospital nearest you or call 9-1-1 for assistance.

Paperwork: Any paperwork for medical equipment, diabetic supplies or handicap parking, FMLA requests or other work-related forms, physical forms, or a request for a written letter from your provider ideally should be discussed & completed during an office visit. Please schedule an appointment and bring all forms and related information. If it is determined after a visit that paperwork is needed, you must provide the appropriate forms and complete a paperwork questionnaire that includes the information necessary to meet your request. Our fee for completing paperwork will depend on the time requirement, and payment is due before your provider can begin filling out the paperwork. Please allow your provider at least two weeks for completion.

Financial Policy

Insurance Claims: We charge what is usual and customary for our area. As a courtesy to you, our patient, we accept most insurance plans and submit claims to these plans on your behalf. It is important that we have accurate and complete information on your insurance coverage. We will not become involved in disputes between you and your insurance company regarding deductibles, copays, covered charges, secondary insurance, etc. other than to provide factual information as necessary. Insurance coverage is a contract between you and your insurance company. We are not a party to that contract, but in order to be a participating provider and file claims for services rendered, we are required to enter into a contractual agreement with each insurance company and ensure that all your insurance plan's requirements are met prior to providing services. It is your responsibility to pay for all services not covered or denied by insurance. We are happy to provide any services you need, but if your insurance plan does not cover certain services, you will be required to pay for the non-covered services. If your insurance plan denies rendered services, in full or part, we will bill the balance to you. Payment of copays, deductibles, and non-covered services is expected at the time of service. Patients without insurance are expected to make payment prior to service. Bray Family Medicine accepts cash, checks, credit cards and health savings accounts. Checks returned for non-sufficient funds will be charged $25.

High Deductible Plans: One of the biggest challenges in healthcare is developing innovative and truly effective methods to help patients live healthier lives at a time when all Americans are struggling to afford ever-increasing health insurance premiums for plans with often such high deductibles that won't ever come close to being met unless catastrophe strikes. A large percentage of Americans are paying a high price for catastrophic coverage but having to forego chronic disease management visits, lab monitoring, and medications refills due to high drug costs, unmet deductibles, and the fear of what these services may cost. Inadequately managing chronic diseases, in turn, greatly increases the risk of a catastrophic event. At Bray Family Medicine, we believe in price transparency. A clear understanding of the costs of your care will enable you to make informed decisions about how your healthcare dollars are spent.

Unmet Deductibles: If you want our services filed as a claim and go towards your deductible, we are required to charge you the allowable rate set by your insurance company. There is such a wide variation in rates among the numerous plans offered by all the different insurance companies that it is impossible to obtain an accurate estimate before services are rendered. If your plan has a deductible that has not yet been met, you are required to pay $75 when you check-in for your visit (excludes behavioral health visit). This payment will be applied towards your deductible. You will receive a bill for the remaining balance which is dependent upon your insurance allowable rates.

Sliding Scale Fee Discount Program: This program is designed to provide free or discounted medical care to those who have no means, or limited means, to pay for visits with a medical provider (uninsured or underinsured). All patients seeking medical services at Bray Family Medicine are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay. Applications are available at the front desk.

Discounted Direct Care Rates: Those with high-deductible insurance plans which are unlikely to be met in the calendar year may decide it's best NOT to file an insurance claim for services rendered and elect instead to take advantage of our discounted direct care rates. For uninsured patients or patients who direct us NOT to file an insurance claim, our discounted direct care rate for an in-person office visit is $75 regardless of complexity or type of visit (excludes behavioral health visit). Our discounted direct care rate for a telemedicine video is $40. Payment in full must be received at the time of service. If lab, procedures, or any other services are indicated, the exact amount of each additional service will be provided for your approval before the service is rendered. A detailed list of all of our discounted direct care rates is available upon request.

Accidents: In the event you are involved in a motor vehicle accident or work-related injury, you are expected to pay for services when rendered. We will gladly provide you with all the necessary paperwork to file your claim with your car insurance or employer.

Payment Plan: We understand that medical bills are often an unplanned expense and can be hard to pay. If your account balance is more than $200, you may request a payment plan.

Nonpayment: We require timely payment of your bill. All copays, deductibles, and coinsurance amounts are due at check-in before you see your provider. If there is a balance due after your insurance has paid, you will receive adequate notifications via email, regular mail or by telephone call. If the balance remains unpaid after three statements have been sent, we will refer your account to a collection agency.

Acceptance & Authorization

- I hereby acknowledge receipt and acceptance of the Bray Family Medicine Clinic Policies.
- I acknowledge that providing my mobile number as a method of contact authorizes Bray Family Medicine to contact me by text message.
- I authorize Bray Family Medicine to obtain/have access to my medical history including my medication history.
- If I choose to participate in a telemedicine visit with my healthcare provider or counselor via telephone or video:
    - I acknowledge that such visit will not be the same as an in-person visit due to the fact that I will not be in the same room as my provider/counselor;
    - I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties;
    - I understand that my healthcare provider/counselor or I can discontinue the telemedicine visit if it is felt that the telephone or video connection is not adequate for the situation.

____ ___________________________

Signature of Patient or Legal Representative Date

Authorization to Release Billing Information & Assignment of Benefits

I authorize insurance benefits to be paid directly to Bray Family Medicine for any services furnished to me by any Bray Family Medicine provider. I further authorize the clinic or its agents to verify employment and wage data in the event collection action becomes necessary.

I consent to the use or disclosure of my protected health information by Bray Family Medicine for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations.

I authorize any holder of medical information about me to release information to my insurance carrier, and when applicable, to the Center for Medicare and Medicaid Service and its agents, as is necessary to determine benefits.

______________________________	______________________________
Signature of Patient or Representative	Date
______________________________	______________________________
Printed Name	Relationship to Patient, if Representative

Bray Family Medicine Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

To Our Patient: The providers at Bray Family Medicine are committed to the protection of your health information. The Health Insurance Portability and Accountability Act requires that we provide notice to each of our patients of how this information is used. We safeguard information about your health and your person (Protected Health Information, PHI). We collect information from you and keep it in a designated record set that contains your health and billing information.

1. USES AND DISCLOSURES AND PROTECTED HEALTH INFORMATION

Treatment: We will use and disclose your health information to provide, coordinate, and/or manage your healthcare and any related service. For example,

- Sending you an appointment reminder
- Obtaining your medical treatment and history and recording it in your chart
- Discussing your care with another healthcare provider

Payment: Your protected health information will be used, and disclosed as necessary, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services such as determining eligibility and coverage and utilization review.

Healthcare Operations: We may use or disclose, as necessary, your protected health information to support standard business activities. These activities include, but are not limited to, quality assessment and improvement activities, training of medical students and licensing. We will share your protected health information with third party business associates that perform various activities for Bray Family Medicine. Whenever an arrangement such as this involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect your privacy. For example: A contract exists between us and the collection agency that handles our past due accounts.

2. OTHER USES AND DISCLOSURES BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke your authorization at any time in writing. There may be cases where your protected health information has already been released prior to the revocation of the authorization.

3. DISCLOSURES TO WHICH YOU HAVE THE OPPORTUNITY TO OBJECT

Others Involved in your Healthcare: Unless you object, we may discuss your protected health information with family members or close friends. The information disclosed will only be that related directly to this person's involvement in your care. If you are unable to agree or disagree, we may disclose this information if we determine that it is in your best interest based on our professional judgment. For example: We may discuss your continuing care plan with the individuals participating in your care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

Communication Barriers: We may use and disclose your protected health information if we are unable to obtain consent from you but feel in our professional judgment that you intend to consent.

4. USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include, but are not limited to:

Required by Law: We will disclose your protected health information when required to do so by federal, state, or local law.

Public Health Reporting: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive information.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your information to health oversight agencies for activities authorized by law such as audits, investigations, and inspections.

Abuse and/or Neglect: We may disclose your protected health information to a governmental entity or agency authorized by law to receive reports of suspected abuse/neglect.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the FDA to report adverse events, product defects, biologic product deviations, etc.

Legal Proceedings: If you are involved in a lawsuit, we may disclose your protected health information in response to a court order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process from someone else involved in the lawsuit, but only if efforts have been made to tell you about the request or to obtain an order from the court.

Law Enforcement: We may disclose protected health information, so long as applicable requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death or injury has occurred as a result of criminal conduct, (5) in the event that a crime occurs on property owned or operated by Bray Family Medicine, PLLC, and (6) in the event of a medical emergency.

Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for them to perform other duties as required by law. Your protected health information may also be disclosed to a funeral director, as authorized by law, for the director to carry out their duties. We may disclose such information in the reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye, or tissue donation purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel, (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Other Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

A. YOUR RIGHTS

You have the right to inspect and obtain a copy of your protected health information. This means that you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain your protected health information. A designated record set contains medical and billing records and any other records that we use in making decisions about you. You may request the record be provided in paper or electronic format. You may be charged a fee for the cost of copying, mailing, or supplies associated with your request.

Under federal and state law, however, you may be denied access to inspect or obtain a copy. Please contact the clinic manager if you have any questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom this restriction applies. You may also request restriction of PHI to a health plan with respect to health care for which you have paid for in full out of pocket. The request and payment must occur in writing in advance of the services being provided.

Your physician is not required to agree to the restriction that you request, except in the case of a requested restriction of PHI to a health plan for purposes of payment or healthcare operations with respect to health care for which you have paid for in full out of pocket. If your physician believes that it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of any alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to the privacy contact listed below.

You have the right to request an amendment to your protected health information. This means that you may request an of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy. Please contact the clinic manager if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made for purposes outside those for treatment, payment, and healthcare operations. You have the right to receive specific information regarding non-routine disclosures that occurred after April 14, 2003. We must respond within sixty (60) days. You may request a shorter timeframe.

You are entitled to receive one (1) free accounting each year. There will be a fee for any additional accounting requests during the year. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a copy of this notice from us. Upon request, you may receive an additional paper or electronic copy of this notice from us.

You have the right to receive a notice following a breach of your unsecured PHI.

COMPLAINTS

If you believe your privacy rights have been violated by Bray Family Medicine, you may file a complaint with us by contacting the Carolyn Francis at 870-464-1515. You may also file a complaint with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint. We will not require you to waive your right to file a complaint with HHS as a condition to receive treatment from us.

ADDITIONAL INFORMATION

This notice was updated, published and becomes effective on November 5, 2021. Bray Family Medicine has a duty as your healthcare provider to maintain your privacy, abide by the terms of this privacy notice, and provide you with a revised copy of this notice if revisions are made.

We reserve the right to change this notice. We reserve the right to make the revised notice effective for protected health information we already have as well as any information we create or receive in the future.

Bray Family Medicine
Notice of Privacy Practices Acknowledgement

The signature below acknowledges a copy of this notice was received (not necessarily read).

______________________________	______________________________
Signature of Patient or Representative	Date
______________________________	______________________________
Printed Name	Relationship to Patient, if Representative

Adult & Teen Health History (12+ yo)

Received: Entered: Appt:

NAME:	DOB:	DATE:
Briefly explain the reason for your visit:	Local Pharmacy:	
	Mail-In Pharmacy:	

CARE TEAM: List all healthcare providers you have seen in the past 1-2 years and the condition(s) each one manages.

Provider:	Condition(s):
Provider:	Condition(s):
Provider:	Condition(s):

MEDICATIONS: List all medications you are currently taking. Include non-prescription medications & vitamins / supplements.

DRUG ALLERGIES: ❑ No ❑ Yes To what?

DRUG NAME & DOSE	INSTRUCTIONS	HOW LONG HAVE YOU TAKEN IT?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SUBSTANCE USE

Smoking status: ❑ never smoked ❑ former smoker ❑ current some day smoker ❑ current every day smoker

How many years have you smoked? ❑ NA yrs | If you quit, how many yrs ago? ❑ 1-5 ❑ 6-10 ❑ 11-15 ❑ 16+

How much do you / did you smoke? ❑ none ❑ 1 pack/wk ❑ 2 packs/wk ❑ ¼ pack/day ❑ ½ pack/day ❑ 1 pack/day ❑ 2 packs/day ❑ 3+ packs/day

Do you or have you ever used e-cigs? ❑ never ❑ former user ❑ current user | How many years? ❑ NA yrs

Do you or have you ever used smokeless tobacco? ❑ never ❑ former user ❑ dips snuff ❑ chews tobacco ❑ moist pwdr tobacco

How much tobacco do you chew daily? ❑ none ❑ 1/day ❑ 2-4/day ❑ 5+/day | How many years? ❑ NA yrs

Level of alcohol consumption: ❑ none ❑ occasional ❑ moderate ❑ heavy

How many times per week do you consume alcohol? ❑ none ❑ occasional ❑ 1 - 2 ❑ 3 - 4 ❑ 5+

Indicate any illicit, recreational, or street drugs you have used in the past. ❑ none

❑ marijuana ❑ cocaine ❑ amphetamine ❑ methamphetamine
❑ ecstasy ❑ heroin ❑ fentanyl ❑ methadone
❑ oxycodone ❑ hydrocodone ❑ tranquilizers / benzos such as Xanax
❑ inhalants ❑ mushrooms ❑ LSD ❑ PCP

SOCIAL HISTORY

Do you have an advanced directive / living will? ❑ Y ❑ N | Do you have a medical power of attorney? ❑ Y ❑ N

How confident are you filling out medical forms by yourself? ❑ extremely ❑ quite a bit ❑ somewhat ❑ a little ❑ not at all

In the past year, had you had concerns about meeting basic needs (food, housing, heat, etc.)? ❑ Y ❑ N

Do you have transportation difficulties? ❑ Y ❑ N | Do you have difficulty affording medications? ❑ Y ❑ N

Sexual orientation: ❑ Homosexual (gay / lesbian) ❑ Heterosexual (straight) ❑ Bisexual ❑ Other: | Assigned sex at birth: ❑ M ❑ F

Gender identity: ❑ Male ❑ Female ❑ Transgender Male (Female-to-Male) ❑ Transgender Female (Male-to-Female) ❑ Gender Non-Conforming

FAMILY HISTORY:

Checkmark and add one or more of the following abbreviations next to the condition that your mother (m), father (f), brother (b), sister (s), child (c), maternal or paternal grandfather (mgf / pgf) or grandmother (mgm / pgm) has had:

- ❑ Family history unknown
- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Heart problems
- ❑ Stroke
- ❑ Aneurysm
- ❑ Kidney disease
- ❑ Thyroid problem
- ❑ Other medical conditions (please list):
- ❑ Asthma
- ❑ Lung disease
- ❑ Anemia
- ❑ Bleeding disease
- ❑ Breast cancer
- ❑ Colon / rectal cancer
- ❑ Leukemia
- ❑ Melanoma
- ❑ Other cancer: ______________
- ❑ Autoimmune disease
- ❑ Osteoporosis
- ❑ Multiple sclerosis
- ❑ Seizures
- ❑ Migraines
- ❑ Dementia
- ❑ ADD/ADHD
- ❑ Depression, anxiety or other mental illness
- ❑ History of drug or alcohol problem

PAST MEDICAL HISTORY:

Add a checkmark and the year next to each condition you have ever had. Use the extra space below to provide further info.

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Heart problems
- ❑ Stroke
- ❑ Aneurysm
- ❑ Blot clot
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Thyroid problem
- ❑ Skin problems
- ❑ Other medical conditions (please list):
- ❑ Anemia
- ❑ Cancer (type) ______________
- ❑ Leukemia
- ❑ Asthma
- ❑ Emphysema / COPD
- ❑ Sleep apnea
- ❑ GERD / Peptic ulcer
- ❑ Crohn's / ulcerative colitis
- ❑ Liver disease
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Chronic pain
- ❑ Fibromyalgia
- ❑ Lupus
- ❑ Rheumatoid arthritis
- ❑ Multiple sclerosis
- ❑ Seizures
- ❑ Migraines
- ❑ Dementia
- ❑ ADD/ADHD
- ❑ Depression, anxiety or other mental illness
- ❑ History of drug or alcohol problem

SURGICAL HISTORY:

Add a checkmark and the approximate year next to each procedure you have had.

- ❑ Brain surgery
- ❑ Eye surgery
- ❑ Ear, nose, throat surgery
- ❑ Thyroid surgery
- ❑ Lung surgery
- ❑ Heart bypass surgery / CABG
- ❑ Heart stent
- ❑ Cardiac stress test
- ❑ Heart valve surgery
- ❑ Heart pacemaker
- ❑ Heart ablation
- ❑ Aortic aneurysm repair
- ❑ Carotid artery surgery
- ❑ Leg artery bypass surgery or stents
- ❑ Gall bladder removal
- ❑ Appendix removal
- ❑ Spleen removal
- ❑ Gastric bypass/sleeve/lap band
- ❑ Colon surgery
- ❑ Hemorrhoid / rectal surgery
- ❑ Hiatal hernia or reflux surgery
- ❑ Hernia, abdominal wall
- ❑ Hernia, groin
- ❑ Prostate surgery
- ❑ Vasectomy
- ❑ Bladder or kidney surgery
- ❑ Kidney stone procedure
- ❑ Other:
- ❑ Skin cancer removal
- ❑ Cosmetic surgery
- ❑ Breast surgery or biopsy
- ❑ Cesarean section
- ❑ Tubal ligation
- ❑ Hysterectomy with removal of ovaries
- ❑ Hysterectomy without removal of ovaries
- ❑ Neck / spine surgery
- ❑ Bone or joint surgery
- ❑ Amputation
- ❑ Varicose vein procedure
- ❑ EGD/upper GI procedure
- ❑ Colonoscopy
- ❑ Other:

HOSPITALIZATIONS:

List all major hospitalizations, excluding surgeries.

Approximate Year	Hospital	Reason for Hospitalization

VACCINES:

Add a checkmark and the approximate year next to each vaccine you have had.

COVID-19:	❑ Unsure	❑ Pfizer - ❑ Full ❑ Partial	❑ Moderna - ❑ Full ❑ Partial	❑ J&J	❑ Booster dose
Pneumonia:	❑ Unsure	❑ Pneumovax23	❑ Vaxneuvance	❑ Prevnar13	❑ Prevnar20
Shingles:	❑ Unsure	❑ Zostavax	❑ Shingrix series - ❑ Full ❑ Partial		