



**James S. Rellas, M.D., P.A., M.S.M.M., F.A.C.C. • David A. Engleman, M.D., F.A.C.C.  
 Brian T. Blatt, D.O., F.A.C.C., C.C.D.S. • William E. Wallace, D.O., F.A.C.O.S., F.C.C.P.**

### Patient Registration Form

**Plano / Hickory Creek / Irving Telephone Number: (972) 939-8294**

**FAX: (214) 731-0240**

TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ OFFICE LOCATION:  HFPRE  HICKORY CREEK  IRVING RECORD NUMBER: \_\_\_\_\_

**PATIENT INFORMATION**

(Please use full legal name, no nicknames) (Mr.  (Mrs.  (Ms.  (Dr.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Who referred you to our practice \_\_\_\_\_ ?

How would you like to be addressed by your physician \_\_\_\_\_ ?

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Mobile/Pager # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Other (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Marital Status: (Married  (Divorced  (Single  (Widowed  Drivers Lic # \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_

Work Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ E-Mail Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Pharmacy Name: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**GUARANTOR INFORMATION:** (List person responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient: (Self  (Spouse  (Parent  (Other) \_\_\_\_\_

**If self and contact information is same as above, check here**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION:** (Please allow receptionist to photocopy your insurance ID cards and Driver's License)

**Primary Insurance**

Plan Name \_\_\_\_\_ Insured's \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Claims Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Secondary Insurance**

Plan Name \_\_\_\_\_ Insured's Name \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Claims Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_



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Patient Name: \_\_\_\_\_  
First Name M.I. Last Name  
Date of Birth: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS:**

I HEREBY AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS TO Dr. \_\_\_\_\_ (physician) for services rendered by the physician or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE NON-PUBLIC INFORMATION:**

I certify that I have received and read a copy of the HeartFirst Patient Information Privacy Policy. I HEREBY AUTHORIZE Dr. \_\_\_\_\_, the physician or his employed agent, to release any medical or incidental information that may be necessary for either medical care or for processing insurance or financial benefits.

**MEDICARE / MEDICAID INSURANCE:**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefit be made to the physician on my behalf.

**LAB/X-RAY/DIAGNOSTIC SERVICES:**

I understand that I may receive a separate bill if I receive lab, x-ray, or other diagnostic services. I understand that I am financially responsible for any balance not covered by my insurance for these services. .

**ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES:**

I acknowledge that my treating physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

**FINANCIAL DISCLOSURE – BAYLOR MEDICAL CENTER at Carrollton**

This disclosure is being provided to you or your health care representative with the option you may be referred to Baylor Medical Center at Carrollton for further treatment or evaluation. I or my immediate family member has an ownership or investment interest in Baylor Medical Center at Carrollton. I am informing you of this financial interest to assist you in making an informed decision about your treatment options. Please let me know if you have any questions about my relationship to Baylor Medical Center at Carrollton or your treatment and evaluation options.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(If different from patient)

GUARANTOR NAME (Please Print): \_\_\_\_\_



### Medical Release of Information Form

**James S. Rellas,**  
M.D., P.A., M.S.M.M.,  
F.A.C.C.

**David A. Engleman,**  
M.D., F.A.C.C.

**Brian T. Blatt,**  
D.O., F.A.C.C.

**William E. Wallace,**  
D.O., F.A.C.O.S., F.C.C.P.

Texas Clinic at Prestonwood  
6957 West Plano Pkwy  
at Marsh Lane  
Suite 1000  
Plano, Texas 75093  
T: **972-939-8294**  
F: 214-731-0240

3600 FM 2181  
Suite 200  
Hickory Creek, Texas 75065  
T: **972-939-8294**  
F: 214-731-0240

7220 N. State Hwy 161  
Suite 300  
Irving, Texas 75039  
T: **972-939-8294**  
F: 214-731-0240

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

Social Security #: \_\_\_\_\_ Previous Name: \_\_\_\_\_

I request and authorize \_\_\_\_\_  
(Name of Physician and Clinic / Practice)

To release the medical record of the above named patient to:

Name of recipient: \_\_\_\_\_

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

City & State: \_\_\_\_\_ Zip: \_\_\_\_\_

Reason for release: \_\_\_\_\_

This request and authorization applies to: (initial appropriate line)

\_\_\_\_\_ Health Care Information relating to the following treatment condition or dates of treatment.

\_\_\_\_\_ This information may contain x-ray reports, lab reports, EKG reports, other diagnostic reports, consults.

\_\_\_\_\_ All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply.)

\_\_\_\_\_ All Health Care information **excluding** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply.)

\_\_\_\_\_ I understand I have the right to revoke this authorization by providing a written request to do so to the above named physician or organization. I understand that the revocation will not apply to information that has already been released.

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

**Unless otherwise revoked, this Authorization will expire six months from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

**Please be aware that our office charges a community standard fee for copying and sending medical records, according to rules adopted by The Texas State Board of Medical Examiners. This fee is \$25.00 for the first 20 (twenty) pages of records and \$0.50 for each additional page. The fee must be paid prior to our office sending out your records. There is a \$35.00 fee for a CD copy of any testing. Please give your phone number(s) below so that our Medical Records clerk can notify you of the exact fee for copying and sending your records. Thank you.**

Home Phone: \_\_\_\_\_

Work / Cell Phone: \_\_\_\_\_



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**HIPAA 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.

**Uses and Disclosures**

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health Care Operations.** Your health information may be used as necessary to support the day-to-day activities and management of Heart First. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law Enforcement.** Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

**Public Health Reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Research**

Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

**Additional Uses of Information**

**Appointment Reminders.** Your health information may be used by our staff to send you appointment reminders. If you do not want us to contact you via the phone numbers you have already provided, and/or leave a voice message via those phone numbers, please check the following box(es):

- Please do not contact me via the phone numbers provided to this practice
  
- Please do not leave a voice message via the phone numbers provided to this practice

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

**Fundraising.** Unless you request us not to, we may use your name and address to support our fundraising efforts. If you do not want to participate in fundraising efforts, please check off the following box.

Please do not use my information for fundraising purposes.

### **Individual Rights**

You have certain rights under the federal privacy standards. These include:

- ◆ The right to request restrictions on the use and disclosure of your protected health information;
- ◆ The right to receive confidential communications concerning your medical condition and treatment;
- ◆ The right to inspect and copy your protected health information;
- ◆ The right to amend or submit corrections to your protected health information;
- ◆ The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- ◆ The right to receive a printed copy of this notice.

### **Practice Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

### **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPAA Privacy Officer  
MedicalEdge Healthcare Group, Inc.  
9229 LBJ Freeway  
Dallas, TX 75243  
(972) 739-3753

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.



**Acknowledgement of Receipt of HIPAA Notice of Privacy Practices**

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HeartFirst reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

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Name of Patient (Print)

Date of Birth

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Signature of Patient

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Date of Signature

---

Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient

**Request for Confidential Communication of Your Protected Health Information**

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls?      Yes    No    N/A

May we leave **messages** on a voice mail at work?      Yes    No    N/A

May we discuss your **appointments/treatment** with your spouse?      Yes    No    N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian?      Yes    No    N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children?      Yes    No    N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in the patient's medical record.

Date Seen: \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ MR# \_\_\_\_\_ Sex: \_\_\_\_\_

What is the name of the doctor who referred you to us? \_\_\_\_\_ Name of your family M.D. \_\_\_\_\_

WHY ARE YOU HERE to see a Cardiology heart doctor? \_\_\_\_\_

**PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY**

**DOCTOR TO FILL OUT**

**Mark X on any HEART PROBLEMS or SYMPTOMS:**

- Chest pains or pressure
- Abnormal rhythm arrhythmias
- Dizziness
- Angina
- Palpitations/Irregular heart beat
- Fainting
- Heart attack
- Heart murmur
- Leg cramps when you walk
- Heart failure
- Blue lips or fingernails
- Swollen legs
- Enlarged heart
- Shortness of breath

**Please mark X if you have:**

- Ever smoked?  Yes  No Year Quit \_\_\_\_\_ Packs per day \_\_\_\_\_
- Diabetes  High blood pressure  Overweight  High triglycerides
- High cholesterol: Total \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_ Trig \_\_\_\_\_

- For woman only:** Could you be pregnant?  Yes  No
- Have you passed menopause / change of life?  Yes  No
- At what age? \_\_\_\_\_ Do you take estrogen? \_\_\_\_\_

**Has a close family member had:** Mother – Father – Sibling Age Occurred Cause of Death

A heart attack?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/>
Angina?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/>
Bypass surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/>
Carotid surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/>
Surgery of leg arteries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/>

**Mark X if you have ever had any of the following PROCEDURES: Indicate approximate year of the procedure**

- Stress test \_\_\_\_\_  Coronary bypass surgery \_\_\_\_\_  Valve surgery \_\_\_\_\_
- Electrocardiogram \_\_\_\_\_  Electrophysiology Study or Procedure \_\_\_\_\_
- Cardiac catheterization / Heart catheterization \_\_\_\_\_  Pacemaker or Defibrillator \_\_\_\_\_
- Coronary Angioplasty balloon arthrectomy / stent \_\_\_\_\_

**Please list all illnesses you are being treated for now or have you been treated for.** Please include date or year

1. \_\_\_\_\_ 3. \_\_\_\_\_
2. \_\_\_\_\_ 4. \_\_\_\_\_

**Please list all injuries or surgeries you have had.** Please include date or year

1. \_\_\_\_\_ 3. \_\_\_\_\_
2. \_\_\_\_\_ 4. \_\_\_\_\_

**Social History:**

MARITAL STATUS:  Single  Married  Separated  Divorced  Widowed  
Spouse name \_\_\_\_\_

CHILDREN:  Yes  No # of Sons \_\_\_\_\_ # of Daughters \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

MAJOR HOBBY: \_\_\_\_\_

DIET:  Regular  No Added Salt  Low Salt  Low Fat / Chol  Diabetic  
 Other: \_\_\_\_\_

ALCOHOL USE:  Yes  No  Former Year Quit \_\_\_\_\_  
 Rarely  Frequently  Socially  Occasionally  Daily

EXERCISE:  Sedentary  Occasionally  Regularly  Active Lifestyle  Physically Unable

**Cardiac Hx**

- CAD  CHF/CM
- Arrhythmia  PVD
- Valve Congen  Other

**HPI**

Onset: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Location: \_\_\_\_\_

**RiskFx**

**Procedures**

**PMH**

**Social Hx Family Hx**



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date Seen: \_\_\_\_\_

**PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY**

**DOCTOR TO FILL OUT**

Please tell us about your medicines names, dose or strength, how many times a day.  
 Include over the counter medications and herbal medicines.  
 Use doctor's column if necessary.

Medications

1.	Name		Dose		Frequency	
	YES	NO	81mg	325mg	Enteric Coated	YES NO
1.	ASPIRIN				Enteric Coated	YES NO
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

Over the Counter Medications Herbs

1.			
2.			
3.			
4.			

**Allergies:**

Do you have any DRUG ALLERGIES?  Yes  No If yes, list them below

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to IODINE, shrimp or shellfish?

Yes  No

Have you ever had a reaction to contrast dye? e.g. Myelogram, Kidney Series, CAT Scan

Yes  No

Have you had the following vaccinations?

Influenza "Flu Shot"  Annually  Other  
 Pneumococcal "Pneumonia" vaccine

Allergies

Vaccinations

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date Seen: \_\_\_\_\_

**PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY**

**DOCTOR TO FILL OUT**

REVIEW OF BODY SYSTEMS: Please mark X YES or NO for each SYMPTOM.

<b>CARDIAC</b>	YES	No		YES	No		YES	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diaphoresis	<input type="checkbox"/>	<input type="checkbox"/>	Orthopnea	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Passing out	<input type="checkbox"/>	<input type="checkbox"/>	PND	<input type="checkbox"/>	<input type="checkbox"/>

<b>VASCULAR</b>	YES	No		YES	No
Claudication	<input type="checkbox"/>	<input type="checkbox"/>	Edema	<input type="checkbox"/>	<input type="checkbox"/>

<b>CONSTITUTIONAL</b>	YES	No		YES	No		YES	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>						

<b>HEENT</b>	YES	No		YES	No		YES	No
Visual Changes	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	ringing	<input type="checkbox"/>	<input type="checkbox"/>

<b>PULMONARY</b>	YES	No		YES	No		YES	No
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis Exposure	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			

<b>GASTROINTESTINAL</b>	YES	No		YES	No		YES	No
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>			
Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Black or Tarry stools	<input type="checkbox"/>	<input type="checkbox"/>			

<b>GENITOURINARY</b>	YES	No		YES	No		YES	No
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urinations at night	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>			

<b>NEUROLOGICAL</b>	YES	No		YES	No		YES	No
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>						

<b>PSYCHOLOGICAL</b>	YES	No		YES	No		YES	No
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>

<b>HEMATOLOGIC</b>	YES	No		YES	No		YES	No
Acute anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>

<b>REPRODUCTIVE</b>	YES	No
Oral contraceptives	<input type="checkbox"/>	<input type="checkbox"/>

<b>ENDOCRINE</b>	YES	No		YES	No
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>

<b>DERMATOLOGICAL</b>	YES	No		YES	No
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Skin sores	<input type="checkbox"/>	<input type="checkbox"/>

<b>MUSCULOSKELETAL</b>	YES	No		YES	No
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pains	<input type="checkbox"/>	<input type="checkbox"/>

**PHYSICAL EXAM**

BP: L \_\_\_\_\_

BP: R \_\_\_\_\_

Pulse: \_\_\_\_\_

Resp: \_\_\_\_\_

Weight: \_\_\_\_\_

Height: \_\_\_\_\_

**PHYSICAL FINDINGS**

**CONST:**

**HEENT:**

**PULM:**

**THORAX:**

**CARDIAC:**

**ABD:**

**VASC:**

**EXT:**

**DERM:**

**MS:**

**NEUROPSYCH:**

**PROC SITE:**

**ASSESSMENT**

- 1.
- 2.
- 3.
- 4.

**PLAN**

- 1.
- 2.
- 3.
- 4.

**TESTING ORDERED**