Dear Patient:

You will find your new patient appointment information below. If you have any questions concerning your appointment, please call us at 864-482-0500. You can reach office staff Monday through Friday from 8:30 a.m. to 12:15 p.m. and 1:15 p.m. to 5:00 p.m. You should receive a courtesy reminder call two days before your appointment.
Please be aware that **we are unable to provide any type of medication refill until your scheduled appointment.**

APPOINTMENT CHECKLIST:

Before Appointment:
Be sure to turn in the attached **New Patient Paperwork including your insurance card at least one week before your scheduled appointment.** If your paperwork is not turned in before your appointment, your appointment may be cancelled.

Day of Appointment: *(Please be sure to bring the following)*

__________ All your medication bottles (prescription, over the counter medications and/or any herbal remedies)

__________ Insurance card(s)

__________ Picture ID

Your appointment is scheduled for ____________________ at __________ am/pm with:

☐ **Dr. Andrea Allyn** ☐ **Dr. Kevin Saunders**
☐ **Apryl Watson, FNP-BC** ☐ **Krishna Patel FNP**

*** Copay amount printed on your insurance will be collected at the time of your appointment.

Thank you,

Mountain Lakes Internal & Family Medicine

10110 Clemson Blvd., Seneca SC 29678 Phone (864) 482-0500 Fax (864) 482-0505

Welcome To Our Practice

We would like to take this opportunity to welcome you to our practice, and look forward to the privilege of meeting your health care needs. Please don't hesitate to let us know at any time if we are not meeting your needs or if you have questions. We have a satisfaction survey that we would like for you to complete after your visit. This will allow us to know how we can better improve our service.

As a member of Oconee Physician Practices and an affiliated health partner with Oconee Medical Center; we are dedicated to providing high quality health care. We are a local non-profit medical group sponsored by the hospital. As a result, any bill you receive from us will have the name of **Oconee Physician Practices** as well as your physician name versus the name of this individual practice location.

For your convenience, you may pay any open balances from other practices affiliated with Oconee Physician Practices at any of our locations.

PLEASE FIND BELOW A LIST OF ALL OUR PRACTICES:

Between the Lakes Primary Care
Blue Ridge Women's Center
Clemson-Seneca Pediatrics
Keowee Family Urology
Mountain Lakes Community Care
Mountain Lakes ENT and Allergy Center
Mountain Lakes Internal Medicine
Mountain Lakes Family Medicine
Oconee Heart Center
Oconee Kidney Center
Rheumatology Consultants
Seneca Medical Associates
Upstate Family Medicine
Upstate Surgical Associates

HOW TO PREPARE FOR YOUR NEW PATIENT VISIT

The New Patient Pack that you received in the mail or picked up at our office will need to be filled out completely and **returned to our office *at least one week* before your scheduled appointment.**

Please be sure to bring all your medication bottles to each of your appointments. This should include all prescription drugs, over the counter medications and/or any herbal remedies you have been taking.

WHAT TO EXPECT AT YOUR NEW PATIENT VISIT

At check in you will be asked to provide your current insurance card and photo identification. Also be prepared to pay any copayment that is printed on your insurance card at that time.

At every appointment your height, weight, temperature, pulse and blood pressure will be checked. We will go over your medical, family, and social history. The provider will do a limited exam and order any necessary diagnostic tests. Please be aware that complete physicals and pelvic exams will not be done at your initial new patient visit. A follow up visit will be scheduled for you at check out if necessary. Please be aware that any cultures/labs that go out will go to Oconee Medical Center. It is our policy not to prescribe controlled substances on a routine basis. If deemed necessary by the physician a referral to a specialist or pain management may be scheduled.

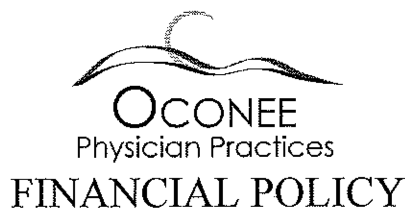
Office Courtesies

A 48 business hours notice is required for all call in prescriptions. Please do not wait until you are out of a medication to call for a refill.

If you need to cancel an appointment please call our office 24-48 hours a head of time. This will allow an opening for the physician to see other patients that may be in need of an appointment.

You can reach office staff Monday through Friday from 8:30 a.m. to 12:15 p.m. and 1:15 p.m. to 5:00 p.m.

10110 Clemson Blvd • Seneca, SC 29672 • 864-482-0500



FINANCIAL POLICY

COLLECTION OF PATIENT AMOUNTS DUE

Insurance companies require that we collect any co-pay or co-insurance amounts at the time of service. We will collect the co-pay amounts at the time of check-in to avoid a wait at check-out. All co-insurance amounts will be collected at the time of check-out. Please understand that you will be responsible for any amounts not paid by your insurance company.

We understand that temporary financial problems may effect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

We understand that there may be special agreements between parents regarding a child's medical expenses. However, the parent that brings the child in for a visit is responsible for making payment on that date of service.

PRESCRIPTION REFILL REQUESTS BY PHONE

We will generally need to see an existing patient back in the office prior to calling in a prescription. However, in rare cases where it's appropriate to write the prescription, there will be a $15.00 charge in order to cover operating costs. This is not generally covered by your insurance.

DISMISSAL OF PATIENTS FOR FINANCIAL REASONS AND MISSED APPOINTMENTS

Patients can be dismissed from the practice for a number of reasons, including the following financial situations:

1. Collection Agency Turnover will result in a dismissal from the practice if a patient fails to pay his or her balance within thirty days of turnover.
2. Expedited dismissal occurs when a patient is not honoring his or her financial responsibilities.

All patients should be given at least thirty days notice before being dismissed from practice unless instructed otherwise by physician.

After a patient is late by more than 15 minutes to the scheduled appointment then the appointment will be considered a "missed" appointment. If a patient arrives after 15 minutes, the practice will follow the physician preference for seeing or rescheduling the patient. If a patient fails to arrive without notice, then it will be considered a "no show." After the second "no show" the patient will be charged a $15 fee that will need to be paid in full before rescheduling the next non-emergent appointment.

A patient "no showing" for three appointments within a 12 month period may be dismissed from the practice under the discretion of the provider.

Absences may be excused by the provider or office manager under extenuating circumstances.

This notice is yours to keep.

301 Memorial Drive, Suite F • Seneca, SC 29672 • (864) 885-7989 • FAX (864) 885-7867

Patient Information

Last Name		Social Sec #	
First Name		Birth Date	
Middle Name		Sex (M or F)	
Street Address		Race	
Suite / Apt #		Primary Language	
City / State / Zip		Marital Status	
Mailing Address		Legal Guardian	
City / State / Zip		Legal Guardian's Primary Phone	
Home Phone	Work Phone	Cell Phone	
Email Address			

Guarantor Information (Person Responsible For Bill)

Last Name		Social Sec #	
First Name		Birth Date	
Middle Name		Sex (Male or Fem)	
Street Address		Relationship	
City / State / Zip		Home Phone:	
Mailing Address		Work Phone:	
City / State / Zip		Cell Phone:	

Employment Information

Patient's Employer		Employer Phone	
Spouse's Employer			

Emergency Contact Information

Name		Relationship		Phone	

Physician Information

Name of Family Physician		City/State	
Name of Referring Physician		City/State	

Insurance Information For Patient– Provide complete and provide copy of insurance card(s)

Primary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Secondary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Additional Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:

I give permission to the provider's to treat the patient. ______________________
Signature of Responsible Party/Self

Assignment of Benefits: I hereby authorize payment of medical benefits directly to Oconee Physician Practices for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Signature Of Patient Or Guardian >> **Date:**

- ○ Between the Lakes
- ○ Blue Ridge Women's Center
- ○ Clemson-Seneca Pediatrics
- ○ Dr. Timothy Sanders Family Medicine
- ○ Keowee Family Urology
- ○ Mountain Lakes Community Care
- ○ Mountain Lakes ENT & Allergy Center
- ○ Mountain Lakes Family Medicine
- ○ Mountain Lakes Internal Medicine
- ○ Oconee Geriatric & Palliative Medicine
- ○ Oconee Heart Center
- ○ Oconee Kidney Center
- ○ Rheumatology Consultants
- ○ Seneca Medical Associates
- ○ South Carolina Cardiology Consultants
- ○ Upstate Family Medicine
- ○ Upstate Surgical Associates

Release of Information Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy

This signed form acknowledges that you have received a copy of our practice's Notice of Privacy Practices as required by Federal Law and our Financial Policy. By signing below you are acknowledging that you understand and have read the notices. The notices are yours to keep.

With whom may we discuss patient's financial information?

Patient Only: [ ]

Name: ______________________ Relationship: ______________________
For patient over age of 18 only

Name: ______________________ Relationship: ______________________
For patient over age of 18 only

May we leave messages regarding appointments?

(Messages regarding any other information will be left as call back request only)

☐ YES ______________________
What Phone Number

☐ NO

Would you like to designate an individual with whom the practice may discuss the patient's medical information? Patient Only: [ ]

Name: ______________________ Relationship: ______________________
For patient over age of 18 only

Name: ______________________ Relationship: ______________________
For patient over age of 18 only

I acknowledge that I have read and received a copy of the No-Show Policy, which outlines a $15.00 charge if I do not notify the office at least 24-hours prior to the scheduled appointment time. _________ (initial)

______________________ ______________________
Print Patient Name **Patient Date of Birth**

______________________ ______________________
Signature of Guarantor/ Patient/ Legal Guardian Date

This authorization is in effect until revoked in writing.

Revision date: 11.15.2013

Mountain Lakes Internal Medicine & Family Medicine
Authorization for Use and Disclosure of Protected Health Information

Patient Identification:

Printed Name: ______________________ Date of Birth: ______________

Address: ______________________ Social Security # ______________

______________________ Telephone: ______________

I authorize the following practice:

______________________ Phone# ______________
______________________ Fax# ______________

to release records identified above to Oconee Physicians Practices'
Mountain Lakes Internal Medicine & Family Medicine

Attn. Dr.______________
10110 Clemson Blvd., Seneca, SC 29678
864-482-0500

PLEASE FAX RECORDS TO: 864-482-0505

Information to be released: From (date) __________ To (date) __________

Please check type of information to be released:

☐ Entire medical record	☐ Pathology report	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results/reports	☐ X-ray reports	☐ X-ray films / images
☐ Operative report	☐ Emergency room record	☐ Itemized bill

_______ *initials* — I acknowledge, and hereby consent to such, that the released information may contain alcohol, *drug abuse,* psychiatric, HIV testing, HIV results, or AIDS information.

Please check the Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the practice. Unless revoked, this authorization will expire on the following date or event ______________________. If no expiration date is set forth this authorization will expire180 days from date of signature.

Re-disclosure

I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that the practice may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize the practice to use and disclose the protected health information specified above.

⇒ **Signature:** ______________________ **Date:** ______________

Authority to Sign if not patient: ______________________

Andrea Allyn, MD • Apryl Watson FNP-BC • Kevin Saunders, MD• Krishna Patel FNP

Controlled Medication Agreement

The purpose of this agreement is to prevent misunderstandings about certain medicines that you will be taking that are controlled substances. This is to help you and your healthcare provider to comply with the law regarding these medications.

I understand that this agreement is essential to the trust and confidence necessary in a healthcare provider/patient relationship.

I understand that if I break this agreement, my healthcare provider ______________________________ will stop prescribing these controlled medications. In this case, my healthcare provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms or a drug-dependence treatment program may be recommended. If participating in a pain management program, I will communicate fully with my healthcare provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not use any prescription medications not prescribed to me. I will not share, sell, or trade my medicine with anyone. I will not attempt to obtain any controlled medications, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines (nerve pills) from any other healthcare provider without the knowledge of my healthcare provider.

I will safeguard my medicine from loss or theft. Lost or stolen medications will **not** be replaced. Police reports do not constitute proof that medication was stolen.

I agree that refills of my prescriptions for controlled medication will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use ____ Pharmacy, located at ____________________________________, telephone number ______________________, for filling prescriptions for all of my controlled medications. I will notify my healthcare provider if I need to change pharmacies.

I authorize my healthcare provider 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 controlled medications. I authorize my healthcare provider to provide a copy of this agreement to my pharmacy and if so desired by my healthcare provider; obtain a prescription history from my pharmacist which will include all prescriptions filled by any and all healthcare providers seen in the prior 12 months. I authorize any health clinics or doctors offices where I have received treatment to release any and all of my personal health information to my current healthcare provider as requested. I agree to waive any applicable privilege or right to confidentiality with respect to these authorizations.
I agree that I will submit to a blood or urine test if requested by my healthcare provider to determine my compliance with my medication regimen. This will be at my own expense.

I understand that I may be called between regularly scheduled appointments for review of medications. I will bring all current prescriptions including any unused medication to every office visit. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I agree that if directed by my healthcare provider, I will undergo medically indicated conservative treatment aimed at reducing my symptoms thus reducing my need for medications. Failure to do so may result in my dismissal.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document was given to me.

This agreement is entered into on this ____________ day of ___________, 201 ___.

Patients Printed Name: ______________________________ Patients DOB: __________________

Patients Signature: ______________________________

Healthcare Provider Signature: ______________________________ Witness: __________________

10110 Clemson Blvd. • Seneca, SC 29678 • 864-482-0500

HEALTH HISTORY QUESTIONNAIRE – Adult

Questions contained in this questionnaire are strictly confidential and will become part of your medical record.

BASIC INFORMATION

Patient Name:	Date of Birth:
Last Provider Seen/Date:	
Allergies/Reaction: (☐None)	

PERSONAL HISTORY

CHILDHOOD ILLNESSES	DATES (*most recent*):	IMMUNIZATIONS	DATES (*most recent*):	HEALTH MAINTENANCE	DATES (*most recent*):
☐ Measles:		☐ Tetanus:		☐ Eye Exam:	
☐ Mumps:		☐ Hepatitis:		☐ EGD:	
☐ Rubella:		☐ Flu:		☐ EKG:	
☐ Chickenpox:		☐ H1N1:		☐ Colposcopy:	
☐ Rheumatic Fever:		☐ Gardasil:		☐ Colonoscopy:	
☐ Polio:		☐ Pneumonia:		☐ Bone Density Screening:	
☐ Other:		☐ Zostavax:		☐ Other:	
☐ Other:		☐ PPD:		☐ Other:	
☐ Other:		☐Other:		☐ Other:	

MEDICAL HISTORY

Please check box labeled **C** *if the problem is* **Current**, *and* **P** *if the problem occurred in the* **Past**.

C	P	RESPIRATORY/ENT	C	P	CARDIOVASCULAR
		Hearing Problems			High Blood Pressure
		Ringing in Ears			Irregular Pulse
		Prolonged Hoarseness			Fainting Spells
		Sinus Trouble			Swollen Ankles
		Vision Problems			Cold Numb Feet
		Bronchitis			Varicose Veins
		Chronic Cough			Dizzy Spells
		Shortness of Breath			Leg Pain/Fatigue
		Eye Pain			Chest Pain/Pressure
		Nose Bleeds			Palpitations
		Sore Throat			Heart Murmur
		Pneumonia	**C**	**P**	EMOTIONAL
		COPD/OSA			Depression
		Asthma			Mental Illness
		Wheezing			Mood Swings
C	**P**	GASTROINTESTINAL			Thoughts of Death
		Appetite			Sleep Problems
		Difficulty Swallowing			Lack of Concentration
		Bloody/Tar-Like Stool			Decreased Work Performance
		Hepatitis			Anxiety
		Nausea/Vomiting			Bipolar
		Bowl Changes	**C**	**P**	URINARY
		Abdominal Pain			>2 Overnight
		Jaundice			Stress Incontinence
		Crohn's Disease			Kidney Stones
		Peptic Ulcer			Blood in Urine
		Gallbladder			Urinary Tract Inf.
		Constipation			Painful
		Diarrhea			Low Flow
		Diverticulosis			Bed Wetting
		Special Diet			

FEMALES ONLY

Menstrual Flow:
☐ Regular ☐ Irregular ☐ Pain/Cramps

Date 1st day of last period:

☐ Flushing/Menopause

Sexually Active: ☐ Yes ☐ No

Sexual Problems: ☐ Yes ☐ No

Birth Control Method:

\# of Pregnancies:

\# of Miscarriages:

\# of Live Births:

\# of Abortions:

☐ Vaginal ☐ C-Section

Date of last Pap Smear:

☐ Normal ☐ Abnormal

Date of last Mammogram:

☐ Normal ☐ Abnormal

MALE ONLY

Check all that apply:
☐ Vasectomy ☐ Circumcision ☐ Inguinal Hernia

Sexually Active: ☐ Yes ☐ No

Sexual Problems: ☐ Yes ☐ No

Prostate Problems: ☐ Yes ☐ No

Last PSA date:

Other:

SURGERIES:

Name *(Last, First, M.I.)*:	**DOB:**

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING: *(List additional on back)*

Please use the below example when completing the medication section.

Pharmacy name and address

Number used by the drugstore to identify this drug for your refills

Person who gets this drug

Instructions about how often and when to take this drug

Name of drug and strength of drug

Number of refills before certain date

Doctor's name

Drugstore phone number

Prescription fill date

Local Pharmacy
123 MAIN STREET
ANYTOWN, USA 11111
(800) 555-5555
DR C. JONES
NO 0060023-08291 DATE 06/23/09
JANE SMITH
456 MAIN STREET ANYTOWN, US 11111
TAKE ONE CAPSULE BY MOUTH THREE TIMES DAILY FOR 10 DAYS UNTIL ALL TAKEN
AMOXICILLIN 500MG CAPSULES
QTY MFG
NO REFILLS - DR. AUTHORIZATION REQUIRED
USE BEFORE 06/23/12
SLF/SLF

Don't use this drug past this date

Medication Name	Dose/Strength	Frequency

Person Completing Form: ______________________________ Date: ____________________

Date:	
Home # :	
Birth date:	
☐ M ☐ F	
Name *(Last, First, M.I.)*:	

SOCIAL HISTORY QUESTIONNAIRE - (ADULT)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

TOBACCO PRODUCTS:

Do you have a history of smoking or currently smoke: ☐ Yes ☐ No

Type: ☐ cigarette ☐ cigar ☐ pipe

Start Date:________________ End Date:________________

Amount of cigarettes:

☐ less than 1 cigarette/day
☐ light (1-9 cigs/day)
☐ moderate (10-19 cigs/day)
☐ heavy (20-39 cigs/day)
☐ very heavy (40+ cigs/day)

Interested in quitting smoking: ☐ yes ☐ no

STOP DATE: ________________

Smokeless:

Do you have a history with smokeless tobacco or currently use:

☐ Yes ☐ No

Type: ☐ chew ☐ snuff ☐ powder

Start Date:________________ End Date:________________

Amount:________________

Interested in quitting smokeless:

☐ yes ☐ no

STOP DATE:________________

Comments:____

ALCOHOL USE:

☐ Non-drinker
☐ Current alcohol user

Type: ☐ beer ☐ hard liquor ☐ wine

Average drinks/week:____________

Drinks/day on typical drinking day:________

High risk alcohol use: ☐ yes

Binge drinker: ☐ yes

Past heavy use: ☐ yes

Patient has been in an alcohol treatment program: ☐ yes ☐ no

Comments:____

CAFFEINE USE:

☐ No caffeine use
☐ Uses caffeine

Type: ☐ coffee ☐ tea ☐ soda

☐ energy drinks ☐ caffeine supplements

Total Amount:

☐ excessive (equiv to 10+ 8oz coffee/day)
☐ heavy (equiv to 4-9 8oz coffee/day)
☐ moderate (equiv to 1-3 8oz coffee/day)
☐ minimal (equiv to < 1 8oz coffee/day)

Comments:____

DIET NUTRITION:

Difficulty chewing: ☐ yes

Difficulty swallowing: ☐ yes

History of eating disorder: ☐ yes

Financial issues affecting the ability to buy the needed food: ☐ yes

Special diet:

☐ diabetic ☐ gluten free ☐ low fat
☐ low sodium ☐ renal ☐ vegan
☐ vegetarian ☐ weight reduction ☐ other

Comments:____

ENVIRONMENT:

Lives alone ☐ yes ☐ no

Patient/Person Completing Form: ________________________________

Relationship: ________________________________

FAMILY HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

BASIC INFORMATION		
Patient Name:	Date of Birth:	Today's date:

FAMILY HISTORY

Please check the box and circle the family member's code that had any of the items listed below.

M=Mother **F**=Father **B**=Brother **S**=Sister **MGF**=Maternal Grandfather **MGM**=Maternal Grandmother **PGF**=Paternal Grandfather **PGM**=Paternal Grandmother

Heart/Cardiovascular		
Angina/Chest Pain/CAD:	☐Y ☐N	M F B S MGF MGM PGF PGM
Heart Attack/Heart Disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
High Cholesterol:	☐Y ☐N	M F B S MGF MGM PGF PGM
High Triglycerides:	☐Y ☐N	M F B S MGF MGM PGF PGM
High Blood Pressure:	☐Y ☐N	M F B S MGF MGM PGF PGM
Ischemic Heart Disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
Sudden Death:	☐Y ☐N	M F B S MGF MGM PGF PGM
PVD/AAA	☐Y ☐N	M F B S MGF MGM PGF PGM
Blockage of Arteries Location(s):__________	☐Y ☐N	M F B S MGF MGM PGF PGM
Aneurysm:__________	☐Y ☐N	M F B S MGF MGM PGF PGM
Endocrine/Metabolic		
Diabetes Mellitus:	☐Y ☐N	M F B S MGF MGM PGF PGM
Thyroid Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Eyes/Ears/Nose/Throat		
Glaucoma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Hearing Loss:	☐Y ☐N	M F B S MGF MGM PGF PGM
Loss of Vision:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Genetic/Birth		
Birth Defects:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Genitourinary		
Endometriosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Kidney Disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
Ovary Disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
Toxemia of Pregnancy:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Blood/Hematologic		
Clotting Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Anemia:	☐Y ☐N	M F B S MGF MGM PGF PGM
Leukemia:	☐Y ☐N	M F B S MGF MGM PGF PGM
Lymphoma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Hemophilia:	☐Y ☐N	M F B S MGF MGM PGF PGM
Sickle Cell Anemia:	☐Y ☐N	M F B S MGF MGM PGF PGM

Mental Health		
Alcoholism:	☐Y ☐N	M F B S MGF MGM PGF PGM
Attention Deficit Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Bipolar Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Depressive Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Mental Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Schizophrenia:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Musculoskeletal		
Osteoarthritis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Rheumatoid Arthritis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Osteoporosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Multiple Sclerosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Scleroderma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Lupus:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Neurologic		
Alzheimer's disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
Dementia:	☐Y ☐N	M F B S MGF MGM PGF PGM
Migraine:	☐Y ☐N	M F B S MGF MGM PGF PGM
Stroke:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Oncologic		
Melanoma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Ovarian Cancer:	☐Y ☐N	M F B S MGF MGM PGF PGM
Prostate Cancer:	☐Y ☐N	M F B S MGF MGM PGF PGM
Skin Cancer:	☐Y ☐N	M F B S MGF MGM PGF PGM
Stomach Cancer:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Respiratory		
Asthma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Pulmonary Embolism:	☐Y ☐N	M F B S MGF MGM PGF PGM
COPD/Emphysema:	☐Y ☐N	M F B S MGF MGM PGF PGM
Cystic Fibrosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Sleep Apnea:	☐Y ☐N	M F B S MGF MGM PGF PGM
Tuberculosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM

Additional Comments: ____

Person Completing Form: __________________________________