Welcome to the medical practice of Doctors Zagar, Nagibina, Raptoulis, and Murali. Arthritis Center focuses on performing to the highest standard, YOUR SATISFACTION. Our objective is to provide you with one of the best medical experiences that you have ever had.

Enclosed you will find a Patient Information Sheet, a HIPAA Form, a Disclosure of Personal Health Information Form and a Medical History Form. Please have these forms filled out and bring them plus any imaging reports and/or lab work pertaining to this visit with you the day of your appointment. These records are very important to your diagnosis and treatment if you are being referred to us because of an abnormal blood test or bone density test (DEXA). We will also need a photo ID and your insurance card(s). All copays and deductibles are due at the time of service.

If you have questions, please do not hesitate to contact our office. Please arrive 15 minutes early for your first appointment, so that we can process the paperwork. If you arrive late, or without the paperwork, your appointment will be rescheduled to another day.

Sincerely,

Karen E. Zagar, MD
Tatiana Nagibina, MD
Gina Raptoulis, DO
Priyanka Murali, DO
And The Staff of Arthritis Center
HIPAA Notice of Privacy Practices

Karen E. Zagar, MD
Tatiana Nagibina, MD
Gina Raptoulis, DO
Priyanka Murali, DO
32615 US HWY 19 N., SUITE 2
Palm Harbor, FL 34684
727-789-2784

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers’ compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.
Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS
The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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 or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.
ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the Arthritis Center's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

__________________________________________________________
Patient Name (Type or Print)

__________________________________________________________
Signature

__________________________________________________________
Date
STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

ARTHRITE CENTER
32615 US HIGHWAY 19 NORTH STE 2
PALM HARBOR, FL 34684

Information to be Used or Disclosed
The information covered by this authorization includes: (check one)

☐ All Health Information ☐ Limited To (e.g. All but my lab results) ______________

Purpose of the Disclosure: Assistance in Care

Persons Authorized to Use or Disclose the Above Information: ARTHRITIS CENTER, INC

Persons to Whom Information May Be Disclosed (e.g. Caregiver, Spouse, Child):

______________________________________

(Name of person or organization)

Expiration Date of Authorization
This authorization is effective through (check one) ☐ _____/_____/____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient’s personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

Name of patient (Type/Print)

______________________________________

Signature of Patient Date

Signature of Patient Representative (if applicable)

______________________________________

Relationship of Patient Representative to Patient (if applicable) Provided By HCSI
MEDICAL RELEASE OF INFORMATION

Date______________________

Print Name _______________________ Date of Birth __________________

Signature _______________________ Social Security Number(last four) ________________

TO ______________________________

FAX __________________ PHONE ________________

I hereby authorize and request you to release any and all information which you may possess relating to my examination and illnesses, including psychiatric and/or psychological information which may be part of my records.

SPECIAL ATTENTION TO:
OFFICE NOTES ______
LABORATORY REPORTS ______
X-RAY REPORTS ______
BIOPSY ______
CT SCANS ______
MRI ______
SPECIAL NOTE:

Please forward to:
Karen Zagar, MD
Tatiana Nagibina, MD
Gina Raptoulis, DO
Priyanka Murali, DO
32615 US HWY 19N
Suite 2
Palm Harbor, FL 34684

Fax (727) 785-3537
Phone (727) 789-2784
Attn: __________________________
PATIENT INFORMATION

Date ___________________________

Patient Name ____________________________

Address ____________________________ City __________ State ______ Zip ______

Primary Phone ____________________________ Secondary Phone ____________________________

Secondary Address ____________________________

DOB ____________________________ Social Security Number ____________________________

Marital Status: S M D W Sex: M / F Height _______ Weight __________

Race: American Indian Asian Black Caucasian Pacific Islander Other

Ethnicity: Hispanic or Non-Hispanic Primary Language: ____________________________

E Mail Address ____________________________ @ ____________________________ Employer ____________________________

Emergency Contact Name ____________________________ Phone ____________________________

Secondary Address ____________________________ City __________ State ______ Zip ______

Referring Physician ____________________________ Phone ____________________________ Fax ____________________________

Primary Care Physician ____________________________ Phone ____________________________

Address ____________________________ City __________ State ______ Zip ______

Your Pharmacy ____________________________ Tel #(____) ____________________________

Address ____________________________ City __________ State ______ Zip ______

CANCELLATION / NO SHOW POLICY

NO SHOW OR SAME DAY CANCELLATIONS WILL BE ASSESSED A $50 FEE. CANCELLATIONS NEED TO BE MADE PRIOR TO 24 HOURS OF YOUR SCHEDULED APPOINTMENT TIME.

X ____________________________

ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS, INCLUDING MEDICARE, IF I AM A MEDICARE BENEFICIARY, BE MADE ON MY BEHALF TO ARTHRITIS CENTER, INC FOR ANY EQUIPMENT OR SERVICES PROVIDED TO ME BY THAT ORGANIZATION.

X ____________________________

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE IMMEDIATELY OF ANY CHANGE IN MY INSURANCE COVERAGE. ON NON-ASSIGNED CLAIMS, I AM FINANCIALLY RESPONSIBLE FOR ALL FEES INCURRED ON MY BEHALF FOR ANY SERVICE FURNISHED TO ME. ON ASSIGNED CLAIMS, I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE, CO-PAYMENT, OR DEDUCTIBLES NOT COVERED BY MY INSURANCE. I FURTHER AGREE TO PAY ANY LEGAL OR OTHER FEES INCURRED IN THE COLLECTION OF ANY DELINQUENT CHARGES FOR WHICH I AM FINANCIALLY RESPONSIBLE.

X ____________________________

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE MEDICARE TO FURNISH ARTHRITIS CENTER, INC INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

X ____________________________
The Arthritis Center Patient History Form

Date of first appointment: _____/_____/_____
Time of appointment:_______ Birthplace: ________________________________

Name: ___________________________ Birthdate: _____/_____/_____

LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: ___________________________ Age:_______ Sex: □ F □ M

STREET

APT# ____________________________ Telephone: Home ( ) Work ( )

CITY STATE ZIP

MARITAL STATUS: □ Never Married □ Married □ Divorced □ Separated □ Widowed

Spouse/Significant Other: □ Alive/Age □ Deceased/Age_______ Major Illnesses____________________

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School________

Occupation________________________ Number of hours worked/average per week________

Referred here by: (check one) □ Self □ Family □ Friend □ Doctor □ Other Health Professional

Name of person making referral: ____________________________________________

The name of the physician providing your primary medical care: ____________________________

Do you have an orthopedic surgeon? □ Yes □ No If yes, Name: ____________________________

Describe briefly your present symptoms:_____________________________________

____________________________________

Date symptoms began (approximate):________________________________________

Diagnosis:______________________________________________________________

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

______________________________________________________________

Please list the names of other practitioners you have seen for this problem

______________________________________________________________

RHEUMATOLOGIC (ARTHHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if “yes”)

<table>
<thead>
<tr>
<th>Yourself</th>
<th>Relative Name/Relationship</th>
<th>Yourself</th>
<th>Relative Name/Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis (unknown type)</td>
<td></td>
<td>Lupus or &quot;SLE&quot;</td>
<td></td>
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<tr>
<td>Osteoarthritis</td>
<td></td>
<td>Rheumatoid Arthritis</td>
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<tr>
<td>Gout</td>
<td></td>
<td>Ankylosing Spondylitis</td>
<td></td>
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<tr>
<td>Childhood arthritis</td>
<td></td>
<td>Osteoporosis</td>
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</tr>
</tbody>
</table>

Other arthritis conditions:______________________________________________

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:

[Diagram of body figures with pain shading indicated]
SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram __/__/____
Date of last eye exam __/__/____
Date of last chest x-ray __/__/____
Date of last Tuberculosis Test __/__/____
Date of last bone densitometry __/__/____

Constitutional
☐ Recent weight gain
   amount
☐ Recent weight loss
   amount
☐ Fatigue
☐ Weakness
☐ Fever

Eyes
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness
☐ Feels like something in eye
☐ Itching eyes

Ears–Nose–Mouth–Throat
☐ Ringing in ears
☐ Loss of hearing
☐ Nosebleeds
☐ Loss of smell
☐ Dryness in nose
☐ Runny nose
☐ Sore tongue
☐ Bleeding gums
☐ Sores in mouth
☐ Loss of taste
☐ Dryness of mouth
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing

Cardiovascular
☐ Pain in chest
☐ Irregular heart beat
☐ Sudden changes in heart beat
☐ High blood pressure
☐ Heart murmurs

Respiratory
☐ Shortness of breath
☐ Difficulty in breathing at night
☐ Swollen legs or feet
☐ Cough
☐ Coughing of blood
☐ Wheezing (asthma)

Gastrointestinal
☐ Nausea relieved by food or milk
☐ Jaundice
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools
☐ Heartburn

Genitourinary
☐ Difficult urination
☐ Pain or burning on urination
☐ Blood in urine
☐ Cloudy, “smoky” urine
☐ Pus in urine
☐ Discharge from penis/vagina
☐ Getting up at night to pass urine
☐ Vaginal dryness
☐ Rash/ulcers
☐ Sexual difficulties
☐ Prostate trouble

For Women Only:
Age when periods began: ____________
Periods regular? ☐ Yes ☐ No
How many days apart? ____________
Date of last period? __/__/____
Date of last pap? __/__/____
Bleeding after menopause? ☐ Yes ☐ No
Number of pregnancies? ____________
Number of miscarriages? ____________

Musculoskeletal
☐ Morning stiffness
Lasting how long?
   _____Minutes _____Hours
☐ Joint pain
☐ Muscle weakness
☐ Muscle tenderness
☐ Joint swelling

List joints affected in the last 6 mos

Integumentary (skin and/or breast)
☐ Easy bruising
☐ Redness
☐ Rash
☐ Hives
☐ Sun sensitive (sun allergy)
☐ Tightness
☐ Nodules/bumps
☐ Hair loss
☐ Color changes of hands or feet in the cold

Neurological System
☐ Headaches
☐ Dizziness
☐ Fainting
☐ Muscle spasm
☐ Loss of consciousness
☐ Sensitivity or pain of hands and/or feet
☐ Memory loss
☐ Night sweats

Psychiatric
☐ Excessive worries
☐ Anxiety
☐ Easily losing temper
☐ Depression
☐ Agitation
☐ Difficulty falling asleep
☐ Difficulty staying asleep

Endocrine
☐ Excessive thirst

Hematologic/Lymphatic
☐ Swollen glands
☐ Tender glands
☐ Anemia
☐ Bleeding tendency
☐ Transfusion/when ____________

Allergic/Immunologic
☐ Frequent sneezing
☐ Increased susceptibility to infection
MEDICATIONS

Drug allergies: □ No □ Yes To what?

Type of reaction: ____________________________________________

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

<table>
<thead>
<tr>
<th>Name of drug</th>
<th>Dose (include strength and number of pills per day)</th>
<th>Reason for Medication (Diagnosis)</th>
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<tbody>
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<td>9.</td>
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<td>10.</td>
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</tbody>
</table>

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. Record your comments in the spaces provided.

<table>
<thead>
<tr>
<th>Drug names/dosage</th>
<th>Length of time</th>
<th>Helped a lot, somewhat, or not at all.</th>
<th>Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Steroidal Anit-Inflammatory Drugs</strong></td>
<td></td>
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<tr>
<td>Circle any you have taken in the past</td>
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<tr>
<td>Ansaid (flurbiprofen)</td>
<td>Arthrotec (diclofenac + misoprostil)</td>
<td>Aspirin</td>
<td>Celebrex (celecoxib)</td>
</tr>
<tr>
<td>Daypro (oxaprozin)</td>
<td>Disalcid (salicylate)</td>
<td>Dolobid (diflunisal)</td>
<td>Feldene (piroxicam)</td>
</tr>
<tr>
<td>Meclofen (meclofenamate)</td>
<td>Lodine (etodolac)</td>
<td>Mobic</td>
<td>Motrin (ibuprofen)</td>
</tr>
<tr>
<td>Tolectin (tometin)</td>
<td>Naprosyn (naproxen)</td>
<td>Oruvail (ketoprofen)</td>
<td>Triistrate (choline magnesium trisalicylate)</td>
</tr>
<tr>
<td>Vioxx (rofecoxib)</td>
<td>Voltaren (diclofenac)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain relievers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
</tr>
<tr>
<td>Codeine (Vicodin, Tylenol 3)</td>
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<tr>
<td>Propoxyphene (Darvon/Darvocet)</td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Disease Modifying Anti-Rheumatic Drugs (DMARDS)</strong></th>
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<tbody>
<tr>
<td>Auranofin, gold pills (Ridaura)</td>
</tr>
<tr>
<td>Gold shots (Myochrysine or Solganol)</td>
</tr>
<tr>
<td>Hydroxychloroquine (Plaquenil)</td>
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<tr>
<td>Penicillamine (Cuprimine or Depen)</td>
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<tr>
<td>Methotrexate (Rheumatrex)</td>
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<tr>
<td>Azathioprine (Imuran)</td>
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<tr>
<td>Sulfasalazine (Azulfidine)</td>
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<tr>
<td>Quinacrine (Atabrine)</td>
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<tr>
<td>Cyclophosphamide (Cytoxan)</td>
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<tr>
<td>Cyclosporine A (Sandimmune or Neoral)</td>
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<tr>
<td>Enbrel</td>
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<tr>
<td>Remicade</td>
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<tr>
<td>Procorba Column</td>
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<tr>
<td>Humira</td>
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<tr>
<td>Other:</td>
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<tr>
<td><strong>Osteoporosis Medications</strong></td>
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<tr>
<td>-----------------------------</td>
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<tr>
<td>Estrogen (Premarin, etc.)</td>
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<tr>
<td>Alendronate (Fosamax)</td>
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<tr>
<td>Etidronate (Didronel)</td>
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<tr>
<td>Raloxifene (Evista)</td>
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<tr>
<td>Fluoride</td>
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<tr>
<td>Calcitonin injection or nasal (Miacalcin, Calcimar)</td>
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<tr>
<td>Risedronate (Actonel)</td>
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<tr>
<td>Prolia</td>
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<tr>
<td>Reclast (Zoledronic Acid)</td>
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</table>

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<tr>
<th><strong>Gout Medications</strong></th>
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</thead>
<tbody>
<tr>
<td>Probenecid (Benemid)</td>
</tr>
<tr>
<td>Colchicine</td>
</tr>
<tr>
<td>Allopurinol (Zyloprim/Lopurin)</td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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</tbody>
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<tr>
<th><strong>Others</strong></th>
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</thead>
<tbody>
<tr>
<td>Tamoxifen (Nolvadex)</td>
</tr>
<tr>
<td>Tiludronate (Skelid)</td>
</tr>
<tr>
<td>Cortisone/Prednisone</td>
</tr>
<tr>
<td>Hyalgan/Synvisc injections</td>
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<tr>
<td>Herbal or Nutritional Supplements</td>
</tr>
</tbody>
</table>

Please list supplements:

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Have you participated in any clinical trials for new medications?  □ Yes  □ No

If yes, please list:

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SOCIAL HISTORY
Do you drink caffeinated beverages? □ Yes □ No
Cups/glasses per day: __________

Do you smoke? □ Yes □ No □ Past – How long ago? __________

Do you drink alcohol? □ Yes □ No □ Number per week __________

Has anyone ever told you to cut down on your drinking?
□ Yes □ No

Do you use drugs for reasons that are not medical? □ Yes □ No
If yes, please list: _______________________________________

Do you exercise regularly? □ Yes □ No
Type ___________________________________________________

Amount per week _______________________________________

How many hours of sleep do you get at night? __________

Do you get enough sleep at night? □ Yes □ No

Do you wake up feeling rested? □ Yes □ No

PAST MEDICAL HISTORY
Do you now or have you ever had: (check if ‘yes’)
□ Cancer (Type: __________) □ Asthma □ Goiter
□ Heart problems (Type: __________) □ Stroke □ Psoriasis
□ Kidney disease (Type: __________) □ Leukemia
□ Cataracts □ Diabetes □ Epilepsy
□ Anxiety/Depression □ Stomach ulcers □ Rheumatic fever
□ Jaundice □ Colitis □ Pneumonia
□ Anemia □ HIV/AIDS □ High Blood Pressure
□ Emphysema □ Glaucoma □ Tuberculosis

Other significant illness (please list): _______________________________________

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.):
______________________________________________

______________________________________________

______________________________________________

Previous Operations

<table>
<thead>
<tr>
<th>Type</th>
<th>Year</th>
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<tbody>
<tr>
<td>1.</td>
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<td>7.</td>
<td></td>
</tr>
</tbody>
</table>

Any previous fractures? □ No □ Yes Describe: _______________________________________

Any other serious injuries? □ No □ Yes Describe: _______________________________________

FAMILY HISTORY:

<table>
<thead>
<tr>
<th>If Living</th>
<th>If Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Age at Death</td>
</tr>
<tr>
<td>Health</td>
<td>Cause</td>
</tr>
</tbody>
</table>

Mother

Father

Number of siblings __________ Number living __________ Number deceased __________

Number of children __________ Number living __________ Number deceased __________ List ages of each

Health of children: ________________________________________________________________

Do you know of any blood relative who has or had: (check and give relationship)

□ Cancer □ Heart disease □ Rheumatic fever □ Tuberculosis

□ Leukemia □ High blood pressure □ Epilepsy □ Diabetes

□ Stroke □ Bleeding tendency □ Asthma □ Goiter

□ Colitis □ Alcoholism □ Psoriasis