Argyle Health Services

PATIENT INFORMATION

□ ***New Patient*** □ ***Established PT***

Patient's FIRST Name: MIDDLE: LAST:

Social Security #:

Birth date: / /	Sex: □ M □ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Not-Employed	Employer Name:
Your Address:	City		State:	Zip Code:
Race: □Decline □White □American Indian /Alaska Nat. □Asian □ Black/African American □Nat.Hawaii/Oth Pac Islander □Other		Ethnic Group: □Non-Hispanic □ Hispanic/Latino □Decline		Language: □English □Spanish □Other:
Primary Phone#: □ Cell □ Work □Home ( )	Alternate Phone#: □ Cell □ Work □Home ( )		Email Address: Appointment reminder by email? □ Yes □ No	
Referring Physician Name:	How did you hear about our office?			
Primary Physician Name:	Reason for visit:	Date of Inj/Onset:		

RESPONSIBLE PARTY:

Person Financially Responsible [Guarantor]

Guarantor's Full Name:

Patient's Relationship to Guarantor:

□ Self Only^Skip to insurance section
□ Other Guarantor^Complete this section

□ Child □ Spouse
□ Other:

Address (if different):

Birth date: / /

Social Security #:

Primary Insurance Company Name:

Plan Name:

Type of Plan: □ PPO □ POS □ HMO □ Medicaid □ Medicare □Tricare □ Medicare HMO □ WC □ Lien

INSURANCE INFORMATION:

Claims Address:

Phone#: ( )

Employer Name & Address:

Policy#:

Group #:

Group Name:

COPAY: $

Annual Deductible: $
□ Met □ Not Met □ Don't Know

Coinsurance: □ None (Plan pays 100%)
□ 80/20 □ 90/10 □ 70/10 □ Don't Know

Effective Date: / /

Is plan thru employer? □ No
□ Yes

Employer address:

Occupation:

Secondary Insurance Company Name:

Plan Name:

Type of Plan: □ Medicare Supplemental
□ Medicaid □ Other Employer/Commercial
□ Spouse's Plan (Pls. complete guarantor section)
□ Other:

Claims Address:

Phone#: ( )

Policy#:

Group #:

Group Name:

Is plan thru employer? □ No □ Yes

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to Argyle Health Services, PLLC dba Adult Health Services as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature:

Date

GENERAL CONSENT

PATIENT NAME: _____ **DATE OF BIRTH:**

PLEASE INITIAL IN EACH SPACE BELOW:

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

I certify that I have received and read a copy of the Argyle Health Services, PLLC dba Adult Health Services Patient Information Privacy Policy. I hereby authorize _____ or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

_____ **AUTHORIZATION TO MAIL, CALL, OR E-MAIL:**

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize an Argyle Health Services, PLLC dba Adult Health Services representative or my practitioner to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the Argyle Health Services, PLLC dba Adult Health Services to that effect in writing.

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

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, X-Ray, EKG, and any other screening service or diagnostic testing ordered by the practitioner or the practitioner's staff. I understand that I may receive a separate bill for these services.

_____ **CONSENT TO TREATMENT:**

I hereby consent to evaluation, testing, and treatment as directed by my Argyle Health Services, PLLC dba Adult Health Services or his / her designee.

Patient Signature: _____ **Date:**

Guarantor Signature: _____ **Date:**
(If different from patient)

Guarantor (Printed) Name:

Financial Policy

Patient Name:_____**DOB:** _____

Effective Jan 1, 2016

Thank you for choosing AHS as your health care provider. **Please carefully read and initial by each statement and sign below.**
This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____I understand that Adult Health Services will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Adult Health Services. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company. _I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

3. I understand that if I am unable to make a scheduled appointment I need to contact Adult Health Services at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

4. _____I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

5. _____Adult Health Services will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Adult Health Services if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending practitioner.

Signature of Responsible Party:_____ **Date:** _____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to practitioner's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Argyle Health Services, PLLC dba Adult Health Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ **Date:**

PATIENT PRIVACY AND HEALTH INFORMATION COMMUNICATION

DIRECTIVE Patient Name: **DOB:**

Email:

In our efforts to comply with the Health Information Privacy Act (HIPAA), we need to be certain that we guard your personal privacy according to your wishes when it comes to your family, friends and co-workers.

- **We are unable to discuss any of your information with anyone unless you designate them below.**
- **Any future changes to the following information must be made in writing.**

_____**I do not wish to disclose any information with anyone.**

I wish to be contacted regarding appointments, tests and test results, diagnoses, treatments, and billing in the following manner: (Please Circle)

May we send you messages via email?	YES	NO	N/A
May we leave messages on a voice mail at your home?	YES	NO	N/A
May we leave messages on a voice mail at work?	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
If you are over the age of 18, still living at home, may we discuss your appointments and / or treatment with your parent(s) or guardian(s)?	YES	NO	N/A
May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls at work?	YES	NO	N/A

I hereby give permission to the staff of Argyle Health Services, PLLC dba Adult Health Services. to disclose and discuss any information related to my medical condition, to include appointments, tests and test results, diagnoses, treatments, billing to / with the following family members (s).

Name DOB Relationship Phone Number

Name DOB Relationship Phone Number

I hereby give permission to the staff of Argyle Health Services, PLLC dba Adult Health Services., in case of an emergency, to contact and notify the following that such emergency exists (these can be different person(s) than those above) as well as how to proceed:

Name DOB Relationship Phone Number

Name DOB Relationship Phone Number

I hereby give my permission to the staff of Argyle Health Services, PLLC dba Adult Health Services.to leave voice mail, text or automated messages regarding medical conditions, to include appointments, tests and test results, diagnoses, treatments, and billing at the following phone numbers:

Phone Numbers for Voice Messages Phone Numbers for Text Messages:

I hereby give permission to the staff of Argyle Health Services, PLLC dba Adult Health Services.to email any information related to my medical condition, to include appointments, tests and test results, diagnoses, treatments, and billing at the following email address:

Email Address

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information. I acknowledge that the information I have provided above is true and correct. In addition, I acknowledge by my signature below that I have received a copy of the "Notice of Privacy Practices" which is in this packet.

Signature **Printed Name** **Date**

Relationship if Patient Representative **Physician Office Representative**

DISCLOSURE REGARDING ANCILLARY SERVICES / RESEARCH PROGRAMS

Ancillary Services

Your provider may refer you to one or more ancillary Services in connection with your medical care. An "ancillary service" is a service that is provided by a third party relating to your medical care or treatment. The following types of services are ancillary services:

- Magnetic Resonance Imaging (MRI)
- Bone Density Imaging
- Mammography
- Nuclear Lab
- Ultrasound
- Laboratory
- Computer Tomography (CT)
- Angiography Vascular
- Laboratory Echo
- Position Emission Tomography
- Sleep Therapy
- X-Ray

In addition, providing Durable Medical Equipment (such as wheel chairs) and Infusion Drug Services are ancillary services.

Your provider may have an economic interest in or other business relationship with the company or other person to whom the provider refers you to obtain an ancillary service. You are not obligated to use the person to whom your provider refers you for an ancillary service. You are free to use any person you choose to provide you with an ancillary service.

Research Programs

Your provider may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug company or may be part of a governmental research program. Your provider may be compensated for services rendered in connection with the research program or another research program. You are not obligated to participate in any research program and we will obtain your permission prior to your participating in a program your provider believes may be appropriate for you.

Please feel free to ask your provider if you have any questions about a particular ancillary service or research program.

Patient Signature Date

Printed Name

DISCLOSURE 01/01/2016

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 READ 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 purposes 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 or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your practitioner, 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 practitioner'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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR your protected health information may be provided to a practitioner to whom you have been referred to ensure that the practitioner has 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 medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations. We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited to:

- Quality control
- Licensing
- Employee reviews
- Training of medical students

For example, we may disclose your protected health information to medical students that see patients in 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 practitioner. We may also call you by name in the waiting room when your practitioner is ready to see you. We may use or disclose your protected health information, as necessary to contact you for test results or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health Issues, Communicable Disease, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, law Enforcement; Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under Lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of 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 this authorization, at any time, in writing, except to the extent that your practitioner or the practitioner's practice has taken an action in relation to the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect and copy your Protected Health Information. Under federal law, however, you may not inspect or copy the following records - psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

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 for the purpose 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 of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions, and whom they apply.

Your practitioner is not required to agree to a restriction that you may request. If practitioner believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications 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 or by fax.

You may have the right to have your practitioner amend 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 we have made, if any, of your Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints - You may complain to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 if you believe your privacy rights have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on Feburary 1, 2016.

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. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name _____ Signature _____ Date_____

PATIENT HISTORY FORM PAGE 1

Name: _____ **Date:**

New Patients

Last Doctor**:**
Address
City, State, Zip
Phone:
Date Last Appointment
Date Last Chest X-ray:

Last EKG date:
Last Physical:

ALLERGIES:

Name of Allergen	Type of Reaction

MEDICATIONS: (List all, including over the counter or others not prescribed for you - you may use back of this form)

Drug Name	Strength/Dose	How Often	Apx Date Started

CURRENT MEDICAL PROBLEMS:

Problem	Doctor	Current Status

PREVIOUS HOSPITALIZATIONS:

Hospital	Doctor	Reason

SURGERIES: (please note approximate date or age)

	Appendectomy		Heart Angioplasty		Hysterectomy		Other:
	Prostate removal		Carotid Artery		Breast Biopsy		
	Cataracts		Stomach Surgery		Mastectomy		
	Hernia Repair		Gall Bladder		Tubal Ligation		
	Vasectomy		Tonsillectomy		C-Section		
	Heart Bypass		Bariatric Surgery		Ovary R / L		

PATIENT HISTORY FORM PAGE 2

Name: _____ **Date:**

OB/GYN HISTORY: (Check Appropriate Items or fill in dates/numbers)

Menses		**Pregnancy**		**PAP**		**Other**	
			How Many Pregnancies?		Date of Last Pap		Are you Breastfeeding?
	Age at onset of periods		How Many Live Births?		Was It Normal?		History of STD?
	Irregular Periods		How Many Premature?		Ever had abnormal Pap?		Birth Control Method:
	Heavy Periods		How Many Miscarriages?				
	Missed Periods		How Many Abortions?				How Many Years?
	Spotting		Are you pregnant?				Hormone Therapy?
			How many Weeks?				
			Pregnancy Complications				

SOCIAL HISTORY: (Check Appropriate Items or fill in dates/numbers)

Tobacco Use	**Alcohol Use**	**Caffeine Use**	**Exercise**

	Currently Smoking		No Alcohol		No Caffeine		No Exercise
	Smoked in Past		# of Drinks per Week		# per Day		Regular Exercise
	Year Started Smoking		Beer		Coffee		Some Exercise
	Year Quit Smoking		Wine		Tea		# of times per Week
	# of Packs Per Day		Liquor		Sodas(Reg)		Walk/Run
	Want to Quit?		Alcohol Abuse		Sodas (Diet)		Weights
	Tried to Quit in Past?		Want to Quit?		Energy Drinks		Yoga/Calisthenics
	Treated in Past?		Treated in Past?				Other:

Illicit Drug Use		**Living Situation**		**Work**		**Hepatitis / HIV Risk**	
	Current	Mar Div Sing Wid			FT		Blood Transfusion
	In Past		Who do you live with?		PT		Multiple Sex Partners
	Desire Treatment?				At Home		Relations with: Drug user, or at risk / infected individual
	IV Drug Use		Is your home safe?		Retired		
	Drugs Used:		Are you abused?		Type of Work:		

IMMUNIZATIONS: (Indicate approximate date of most recent)

	Flu		Pneumonia		Prevnar 13		Other:
	Shingles		Tetanus/Tdap				

PREVENTATIVE HEALTH: (Please answer yes or no, or provide date for the following)

Y N	Diet: Are you interested in information on diets for weights, cholesterol or diabetes?
Y N	Calcium intake: Do you know women need about 1000 mg of calcium intake per day?
	Date of last Bone Density Testing
	Date of last Colonoscopy
	Date of last Mammogram

PATIENT HISTORY FORM PAGE 3

Name: _____ **Date:**

DIABETIC HEALTH: (Please answer yes or no, or provide date for the following)

Y N	Are you Diabetic?
Y N	Do you test your sugar at home with a glucose meter?
Y N	Do you know what to do if your sugar is too high or too low?
	Date of last diabetic foot exam
	Date of Last Diabetic (Retinal) Eye exam - Please provide name of doctor as well
	When did you last attend diabetic education courses?
	Date and reading of last A1c test

Alcoholism	
Anemia	
Arthritis	
Bleeds Easily	
Blood Clots	
Breast Cancer	
Cardiovascular Disease	
Colon Polyps	
Colon Cancer	
Diabetes	

High Blood Pressure	
Iron Deficiency	
Kidney Disease	
Mental Illness	
Migraine	
Prostate Cancer	
Stroke	
Seizures	
Suicide	
Thyroid Disease	

	Living?	Age	Present Health Problems or Cause of Death
Father	Y N		
Mother	Y N		
Brothers	Y N		
Sisters	Y N		
Children	Y N		

FAMILY HISTORY: (Please indicate which relatives have the following health problems (ie: Mother, Father, sister, aunt, etc) Indicate current age(s) or age at time of death

ADVANCED DIRECTIVES: (Please answer yes or no, or provide the requested information for the following)

Y N	Do you have a Living will?
Y N	Are you an Organ Donor?
Y N	Do you have a Durable power of attorney for health care?
	Name of Designee:
	Relationship:
Y [UN	Have you discussed the above matters with your family and spouse?
	Where can these documents be located in case of emergency?

Blank forms for advanced directives and medical power of attorney are available upon request. These forms are not intended as legal information, but general information on issues commonly encountered. Argyle Health Services, PLLC dba Adult Health Services is not a law firm and is not a substitute for an attorney.

I certify that the information on this form is complete and correct

Signature: _____ **Date:**

Relationship to patient: _____

REVIEW OF SYSTEMS

Name: _____ **Date:**

SYMPTOM REVIEW: (Please check only those items which are currently affecting you or that you wish to discuss)

HEAD AND NECK		**DIGESTIVE**		**MUSCULOSKELETAL**	
□	frequent headaches	□	heartburn	□	aching muscles or joints
□	neck pain	□	bloated stomach	□	swollen joints
□	neck lumps or swelling	□	belching	□	back or shoulder pain
EYES		□	stomach pain	□	painful feet
□	wear glasses or contacts	□	nausea	□	handicapped
□	blurry vision	□	vomited blood	**SKIN**	
□	eyesight worsening	□	difficulty swallowing	□	skin problems
□	sees double	□	constipation	□	itching or burning skin
□	sees halo	□	loose bowels	□	bleeds easily
□	eye pain or itching	□	black stools	□	bruises easily
□	watery eyes	□	grey stools	**NEUROLOGICAL**	
□	eye trouble	□	pain in rectum	□	faintness
EARS		□	rectal bleeding	□	numbness
□	hearing difficulties	**URINARY**		□	convulsions
□	earache	□	night frequency	□	change in handwriting trembles
□	ringing ears	□	day frequency	**MOOD**	
□	buzzing in ears	□	wets pant or bed	□	nervous with strangers
□	motion sickness	□	burning on urination	□	difficulty in making decisions
MOUTH		□	brown, black or bloody urine	□	lack of concentration or memory
□	dental problems	□	difficulty starting urine	□	lonely or depressed
□	swelling on gums or jaws	□	urgency	□	cries often
□	sore tongue	□	weak urine stream	□	hopeless outlook
□	taste changes	**MALE GENITAL**		□	difficulty relaxing
NOSE and THROAT		□	homosexual/bisexual	□	worries a lot
□	congested nose	□	more than 5 sexual partners	□	frightening dreams or thoughts
□	running nose	□	prostate trouble	□	shy or sensitive
□	sneezing spells	□	discharge	□	dislikes criticism
□	head colds	□	lumps on testicles	□	loses temper
□	nose bleeds	□	painful testicles	□	annoyed by little things
□	sore throat	□	last PSA:	□	work or family problems
□	enlarged tonsils	**FEMALE GENITAL**		□	sexual difficulties
□	hoarse voice	□	last menstrual period:	□	considered suicide
RESPIRATORY		□	post-menopausal or hysterectomy	□	desired psychiatric help
□	wheezing	□	irregular periods	□	victim of abuse
□	coughing spells	□	noticed vaginal bleeding	**GENERAL**	
□	coughing up phlegm	□	abnormal periods	□	gained/lost more than 10 pounds
□	coughed up blood	□	heavy bleeding during periods	□	tends to be too hot or cold
□	chest colds	□	bleeding between periods	□	loss of interest in eating
□	more sweating, night sweats	□	bleeding after intercourse	□	always hungry
CARDIOVASCULAR		□	recent vaginal itching/discharge	□	thirstier lately
□	high blood pressure	□	homosexual/bisexual	□	armpits or groin swelling
□	racing heart	□	more than 5 sexual partners	□	exhausted or fatigued
□	chest pain	□	no monthly breast exam	□	sleeping difficulties
□	dizzy spells	□	lump or pain in breasts	**OTHER**	
□	shortness of breath	□	complications with birth control	□	
□	shortness of breath at night	**SOCIAL HISTORY**		□	
□	more pillows to breathe	□	drive vehicle over 25,000 miles per year	□	
□	swollen feet or ankles	□	always wear seat belts	□	
□	leg cramps	□	foreign travel in the last 6 months	□	
□	heart murmur			□	