PATIENT INFORMATION

Susan Biegel M.D.

Date: _____
Referred by: _____

Name
□Mr. □Mrs. □Ms. _____
First Middle Last

Age _____ Date of Birth _____ SSN _____

Marital Status □ Single □ Married □ Divorced □ Separated □ Widow □ Widower

Home Address _____

_____

Phone Numbers Home _____ Cell*_____ Work _____

Email Address _____

May we contact you through your email to confirm appointments and alert you of updates? □ Yes □ No

*May we contact you by texting your cell phone? □ Yes □ No

Spouse's Name _____ DOB _____
First Middle Last

Emergency Contacts

1. Name _____ Phone Number _____
2. Name _____ Phone Number _____

EMPLOYMENT INFORMATION

Patient Employed By _____

Occupation _____ Work Number _____

Address _____

_____

Spouse Employed By _____

Occupation _____ Work Number _____

Address _____

_____

INFORMATION FOR YOUR PHYSICIAN

Name _____ DOB _____ Age _____
Place of Birth _____ Race/Nationality of Parents _____
Religion _____ Education _____ Age on completion _____
Occupation _____ For how long? _____
Where and when have you lived or traveled outside the U.S. and Canada? _____
_____

	Living	Age or Age at death	Present health or cause of death
Father	□ Yes □ No	_____	_____
Mother	□ Yes □ No	_____	_____
Spouse	□ Yes □ No	_____	_____

Present marriage length _____ Previous marriage length _____
Brothers # Living _____ Health _____
Dead _____ Cause of death _____
Sisters # Living _____ Health _____
Dead _____ Cause of death _____
Children # Living _____ Health _____
Dead _____ Cause of death _____
Please circle illnesses which have occurred in any of your blood relatives.

Diabetes	Bleeding Tendency	Kidney Disease	Tuberculosis	Heart Disease
Stroke	High Blood Pressure	Nervous Illness	Allergy	Cancer

Please circle illnesses or conditions you have had.

Diabetes	Glaucoma	Heart Trouble	Syphilis	Vein Trouble	Cancer
Asthma	Jaundice	Gonorrhea	Bleeding Tendency	Tuberculosis	
Pneumonia	Kidney Disease	Rheumatic Fever	Nervous Disorder		

Please list other illnesses not requiring operation for which you were hospitalized.
_____
_____
Have you had serious injuries, broken bones, etc.? If yes, please list. _____
_____
Have you had allergy or sensitivity to medicines or other substances? If yes, please describe. _____
_____
Do you use tobacco now? _____ In the past? _____ Amount _____ For how long? _____
Do you use alcoholic beverages? _____ Type _____ Amount _____ For how long? _____
Please check the diseases against which you have been immunized.
□ Smallpox □ Tetanus □ Typhoid □ Polio □ Influenza □ Other _____
Please list previous operations, giving dates, hospital where performed, and the name of the surgeon. _____
_____
Please list previous x-ray therapy or similar treatment. _____
_____
Medications _____
_____
Menstrual History: last period _____ Periods are □ Regular □ Irregular
# of Pregnancies _____ # of Miscarriages _____
Have you take Cortisone-type drugs? _____ Oral Contraceptives? _____
Have you received a blood transfusion? _____ Date _____
Your weight dressed _____ How long have you been this weight? _____
Please write the main reason you came to the office _____

Provider's Signature _____ Date _____

Susan Biegel MD

Name _____ DOB _____

- **1 in 3 Americans have undiagnosed sleep disorders.**
- **Over 40 million Americans are chronically ill with various sleep disorders.**
- **40% of Americans report difficulty either falling asleep or staying asleep.**
- **It is estimated that 90% of the population of obstructive sleep apnea has not been diagnosed.**

Please check the box only if you answer "yes" to the questions.

		Points
Have you been told that you stop breathing while you're sleeping?	□ Yes	8
Have you ever fallen asleep or nodded off while driving?	□ Yes	6
Do you awaken suddenly with shortness of breath, gasping or with your heart racing?	□ Yes	6
Do you feel excessively sleepy during the day?	□ Yes	4
Has anyone ever told you that you snore while you're sleeping?	□ Yes	4
Have you had a weight gain and found it difficult to lose?	□ Yes	2
Have you taken medication for or been diagnosed with high blood pressure?	□ Yes	2
Do you kick or jerk your legs while sleeping?	□ Yes	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	□ Yes	3
Do you wake up with headaches during the night or in the morning?	□ Yes	3
Do you have trouble falling asleep?	□ Yes	4
Do you have trouble staying asleep once you fall asleep?	□ Yes	4

Add the points together when you answered "yes".

Score & Risk Factor _____

Patient Consent

I hereby consent to the disclosure of my responses to this Sleep Apnea Questionnaire for the purpose of assisting in the diagnosis and treatment of a potential sleep disorder. I understand that as part of the treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent such discloser for these permitted uses, including, but not limited to, disclosers via fax. I fully understand and accept the terms of this consent.

Signature _____ Date _____

Your doctor is screening for sleep apnea with the above questionnaire and may recommend you for a sleep study. If you are recomme4nded for a sleep study by your doctor, the *Institue of Sleep and Wellness* will contact you to schedule your sleep study and verify your insurance.

This questionnaire was developed based upon published articles by the American Academy of Sleep Medicine (A.A.S.M.).

BILLING POLICIES AND PROCEDURES

1. Appointments not cancelled 48 hours prior to your scheduled time will be charged $50 per appointment.
2. We provide courtesy billing for patients with accurate insurance billing information including copy of insurance cards, claims address and claim form if required. If this information is not given at the time of service, it will be the patient's responsibility to pay for the services rendered.
3. If you have a change in insurance, it is your responsibility to alert our office of this change. If you fail to do this before services are rendered, it will be your responsibility to pay for the services.
4. It is your responsibility to understand your insurance policy and its benefits. Make sure you understand how it works in regard to co-pays, deductibles and co-insurance. **Please make sure you know what <u>is</u> and what <u>is not</u> covered.**
5. Insurance companies do not always pay the entire bill. It is to be understood that any balance after payment by the insurance company will be billed to you and should be paid promptly or an arrangement made.
6. Your insurance is a contract between you, your employer and the insurance company.
7. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. In the event the insurance does not cover the payment for services, they are the patient's responsibility.
8. It is your responsibility to check with your insurance company if prior authorization is required.
9. HMO PATIENTS: It is your responsibility to make sure that:
    a. Your policy is effective for the IPA you have selected and the PCP you have chosen is correct on your card.
    b. Your co-pay is paid at the time of service, if you have a co-pay.
    c. If you have services done and we are not the PCP listed, you may be liable for the bill.
10. We do accept assignment of benefits from Medicare. As a courtesy we will bill your secondary insurance. Any balance not covered will be the patient's responsibility.
11. CASH PATIENTS: There may be charges in addition to your initial office visit charge for procedures and surgeries.
12. **All** co-pays and deductibles are payable at the time of service.
13. **All** accounts are due and payable within 60 days from the date of service unless arrangements have been made.

_____ _____

Signature of Patient/Responsible Party Date

INSURANCE INFORMATION & ELIGIBILITY GUARANTEE

Patient's Name _____ DOB _____

Subscriber's Name _____ DOB _____

Contract Name (i.e. Blue Cross…)_____

Medical Group (if HMO) (i.e. Regal, IEHP…) _____

Policy Number _____ Group Number _____

I understand that if the above is not true, or if I am ineligible under the terms of my health plan and/or employer's group's Medical and Hospital Subscriber Agreement, I am financially responsible for all charges for services rendered. Additionally, assuming my eligibility for benefits is not established as set forth above, I agree to pay for all services within 60 days of receiving a bill from this office.

_____ _____

Signature Date

_____ _____

Print Name DOB

Susan Biegel M.D. Inc.
1004 W Foothill Blvd Suite 200
Upland, CA 91786
Tel. (909) 985-1908 Fax (909) 963-1800

Dear Patient,

This is our office policy: if you do not keep your appointments, with the doctors or other providers, or call and give a 48-hour notice of cancellation, **you will be charged a $50 fee per every missed appointment.**

Thank you for your courtesy.

_____ _____
Signature Date

_____ _____
Print Name DOB

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way related to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by the Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and Federal Arbitration (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of the agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: Susan Biegel M.D.

By: _____
Signature of Physician Date

By: _____
Print Name of Translator Date

By: _____
Signature of Translator Date

By: _____
Print Name of Patient Date

By: _____
Signature of Patient Date

By: _____
Print Name of Representative & Relationship with Patient Date

By: _____
Signature of Patient's Representative Date

HIPAA NOTICE OF PRIVACY PRACTICES

Susan Biegel M.D.
1004 W Foothill Blvd Ste 200
Upland, CA 91786
Tel (909) 985-1908 Fax (909) 963-1800

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 of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right 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 Disclosure 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, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. 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.

Health 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 activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical 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.

We may use or disclose your protected health information in 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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosers to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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 physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

HIPAA NOTICE OF PRIVACY PRACTICES

Susan Biegel M.D.
1004 W Foothill Blvd Ste. 200
Upland, CA 91786
Tel (909) 985-1908 Fax (909) 963-1800

Your Rights
The following is a statement of your rights with respect to your protected health plan.

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 health care 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 or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another Health Professional.

You have the right to request to 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.

You have the right to have your physician amend your protected health information. If we deny 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 us or 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 privacy contact of your complaint. We will not retaliate against you for filling 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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

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

_____ _____
Signature Date

_____ _____
Print Name DOB

ADVANCED DIRECTIVES

Susan Biegel M.D.
1004 W Foothill Blvd Ste. 200
Upland, CA 91786
Tel (909) 985-1908 Fax (909) 963-1800

This acknowledgment states that the physician, or one of his/her staff members, has provided me information concerning Advanced Directives.

1. I am age 18 or older. Yes No

2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.

3. I am aware that the Advanced Directives may be any one of the following:

    a. A Durable Power of Attorney for Health Care.
    b. The Declaration in the A Natural Death Act – e.g. A Living Will
    c. I may write down my wishes on a piece of paper so that my family may use the document in deciding my medical treatment, in the event I am unable to do so.

_____ _____
Signature Date

_____ _____
Print Name DOB

This document will become part of my medical record.

Susan Biegel M.D.
1004 W Foothill Blvd Ste 200
Upland, CA 91786
Tel (909) 985-1908 Fax (909) 963-1800

_____ _____
Signature Date

_____ _____
Print Name DOB

Please let us know who we could thank for the referral!!!

- ☐ Family: _____
- ☐ Friend: _____
- ☐ Physician: _____
- ☐ Insurance Roster: _____
- ☐ Yellow Pages: _____
- ☐ Other: (please specify) _____

Thank you for your support!!!

Dr. Susan Biegel and Staff

AUTHORIZATION TO RELEASE HEALTH INFORMATION

_____ _____
Print Name DOB

NOTICE
Susan Biegel M.D. and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep you health information confidential.

I authorize the doctors below to release health information to:

Susan Biegel M.D.
1004 W Foothill Blvd Ste 200
Upland, CA 91786
Tel (909) 985-1908
Fax (909) 963-1800

_____ _____
Signature (of Patient or Patient's Legal Representative) Date

Doctor #1 Name: _____

Address: _____

Phone #: _____ Fax #: _____

Doctor #2 Name: _____

Address: _____

Phone #: _____ Fax #: _____

Doctor #3 Name: _____

Address: _____

Phone #: _____ Fax #: _____

Witness _____
(only if patient is unable to sign) Relationship to Patient

Interpreter _____
Relationship to Patient

*********Unless otherwise revoked, this authorization expires in 1 year*********

Susan Biegel M.D. Inc.
1004 W Foothill Blvd Suite 200
Upland, CA 91786
Tel. (909) 985-1908 Fax (909) 963-1800

Dear Patient,

This is our office policy: if a service is performed and your Insurance is not eligible for the period in which the service was rendered, **you are responsible for the payment of the service(s) that was rendered.**

Thank you for your courtesy.

_____

Signature Date

_____ _____

Print Name DOB

Physician Orders of Life-Sustaining Treatment (POLST)

HIPAA permits disclosure of POLST to other health care professionals as necessary.

_____

Name (please print) DOB Date form prepared

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

A (check one)	**CARDIOPULMONARY RESUSCITATION (CPR):** **Person has no pulse and is not breathing.** ☐ Attempt Resuscitation/ CPR (Section B: Full treatment required) ☐ Do NOT attempt resuscitation (**A**llow **N**atural **D**eath) When not in cardiopulmonary arrest, follow orders in **B** and **C**.
B (check one)	**MEDICAL INTERVENTIONS:** **Person has pulse and/or is breathing.** ☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. **Transfer** if comfort needs cannot be met in current location. ☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotic, and IV fluids as indicated. Do not incubate. May use non-invasive positive airway pressure. Generally avoid intensive care. ☐ **Do NOT transfer to hospital for medical interventions. Transfer if** comfort needs cannot be met at current location. ☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. **Transfer** to hospital as indicated. *Includes intensive care.* **Additional orders** _____ _____
C (check one)	**ARTIFICIALLY ADMINISTED NUTRITION:** **Offer food by mouth if feasible and desired.** ☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. **Additional orders** _____ _____
D	**SIGNATURES AND SUMMARY OF MEDICAL CONDITION:** **Discussed with:** ☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other: _____
	PHYSICIAN'S INFORMATION: Susan Biegel M.D. 1004 W Foothill Blvd Ste 200 Upland, CA 91786 (909) 985-1908 Fax (909) 963-1800
	SIGNATURE OF PATIENT, DECISIONMAKER, PARENT OF MINOR OR CONSERVATOR By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form. _____ Signature Print Name Relationship
	SUMMARY OF MEDICAL CONDITION

Physician Orders of Life-Sustaining Treatment (POLST)

HIPAA permits disclosure of POLST to other health care professionals as necessary

PATIENT INFORMATION

Name	DOB	Date form prepared
Address		Phone number

CONTACT INFORMATION FOR DECISIONMAKER, PARENT OF MINOR OR CONSERVATOR

Name	DOB	Date form prepared
Address		Phone number

Directions for Health Care Professional

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A person within capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void a POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interest.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

REVIEW OF SYSTEMS

Susan Biegel MD

Date _____

Patient's Name _____ DOB _____

General
□ Yes □ No Weight loss or gain
□ Yes □ No Fatigue/ tiredness
□ Yes □ No Weakness
□ Yes □ No Trouble sleeping
□ Yes □ No Night sweats

Skin
□ Yes □ No Rashes
□ Yes □ No Lumps
□ Yes □ No Bruising easily
□ Yes □ No Itching/ pruritis
□ Yes □ No Dryness
□ Yes □ No Color changes
□ Yes □ No Losing hair
□ Yes □ No Brittle nails
□ Yes □ No Moles
□ Yes □ No Acne
□ Yes □ No Lesions

Head
□ Yes □ No Headache
□ Yes □ No Head injury
□ Yes □ No Neck pain
□ Yes □ No Facial pain

Eyes
□ Yes □ No Vision loss/ changes
□ Yes □ No Glasses or contacts
□ Yes □ No Pain
□ Yes □ No Redness
□ Yes □ No Blurry or double vision
□ Yes □ No Flashing lights
□ Yes □ No Specks
□ Yes □ No Glaucoma
□ Yes □ No Cataracts
□ Yes □ No Dry eyes
□ Yes □ No Itchy eyes
□ Yes □ No Watery eyes
□ Yes □ No Last eye exam

Nose
□ Yes □ No Stuffness
□ Yes □ No Discharge (yellow/ green/ clear)
□ Yes □ No Itching
□ Yes □ No Hay fever
□ Yes □ No Nosebleeds
□ Yes □ No Sinus pain
□ Yes □ No Sneezing

Throat
□ Yes □ No Bleeding
□ Yes □ No Dentures
□ Yes □ No Sore tongue
□ Yes □ No Hoarseness
□ Yes □ No Thrush
□ Yes □ No Non-healing sores
□ Yes □ No Need to clear throat frequently

Ear
□ Yes □ No Decrease hearing
□ Yes □ No Ringing in ears
□ Yes □ No Earache
□ Yes □ No Drainage
□ Yes □ No Spinning of room

Neck
□ Yes □ No Lumps
□ Yes □ No Swollen glands
□ Yes □ No Pain
□ Yes □ No Stiffnes

Breasts
□ Yes □ No Lumps
□ Yes □ No Pain
□ Yes □ No Discharge (clear/ bloody/ milky/ green)
□ Yes □ No Rash
□ Yes □ No Self-exams
□ Yes □ No Breast feeding

Respiratory
□ Yes □ No Snoring
□ Yes □ No Cough
□ Yes □ No Sputum (yellow/ green/ clear)
□ Yes □ No Coughing up blood
□ Yes □ No Shortness of breath
□ Yes □ No Wheezing
□ Yes □ No Painful breathing
□ Yes □ No Trouble breathing after exertion
□ Yes □ No Stop breathing while sleeping (apnea)

Cardiac
□ Yes □ No Chest pain or discomfort (stabbing/ sharp/ pressure)
□ Yes □ No Tightness
□ Yes □ No Palpitations (heart pounding)
□ Yes □ No Shortness of breath with activity (dyspnea)
□ Yes □ No Difficulty breathing lying down (orthopnea)
□ Yes □ No Swelling of ankles
□ Yes □ No Sudden awakening from sleep with shortness of breath (paroxysmal nocturnal dyspnea)

PLEASE FLIP OVER

→

Doctor's Signature _____

REVIEW OF SYSTEMS

Susan Biegel MD

Date _____

Patient's Name _____ DOB _____

Gastrointestinal

□ Yes □ No Swallowing difficulties (dysphagia)
□ Yes □ No Heartburn
□ Yes □ No Change in appetite
□ Yes □ No Nausea
□ Yes □ No Change in bowel habits
□ Yes □ No Rectal bleeding (hematochizia)
□ Yes □ No Constipation
□ Yes □ No Diarrhea
□ Yes □ No Yellow eyes or skin
□ Yes □ No Black stool (melena)
□ Yes □ No Abdominal pain
□ Yes □ No Vomiting
□ Yes □ No Laxative use
□ Yes □ No Antacid use
□ Yes □ No History of hepatitis

Urinary

□ Yes □ No Frequency
□ Yes □ No Urgency
□ Yes □ No Burning or pain (dysuria)
□ Yes □ No Blood in urine (hematuria)
□ Yes □ No Incontinence (leaking when sneezing)
□ Yes □ No Change in urinary strength (weak urine stream)
□ Yes □ No Nighttime frequency (nocturia)
□ Yes □ No Loss of libido
□ Yes □ No Erectile dysfunction

Vascular

□ Yes □ No Calf pain with walking
□ Yes □ No Leg cramping
□ Yes □ No Ulceration of leg
□ Yes □ No History of blood clots in legs
□ Yes □ No Discolation of skin in legs
□ Yes □ No Varicose veins (DVT)

Musculoskeletal

□ Yes □ No Muscle or joint pain
□ Yes □ No Stiffness
□ Yes □ No Back pain
□ Yes □ No Redness of joints
□ Yes □ No Swelling of joints
□ Yes □ No Trauma
□ Yes □ No Nocturnal leg cramps

Neurologic

□ Yes □ No Dizziness
□ Yes □ No Fainting
□ Yes □ No Seizures
□ Yes □ No Weakness
□ Yes □ No Numbness
□ Yes □ No Tingling
□ Yes □ No Tremor
□ Yes □ No Memory loss (dementia)
□ Yes □ No Unstable gait (utaxia)
□ Yes □ No Falls
□ Yes □ No Behavioral changes

Hematologic

□ Yes □ No Ease of bruising
□ Yes □ No Ease of bleeding

Endocrine

□ Yes □ No Heat or cold intolerance
□ Yes □ No Sweating
□ Yes □ No Frequent urination
□ Yes □ No Thirst/ dry mouth
□ Yes □ No Change in appetite
□ Yes □ No Weight gain or loss

Psychiatric

□ Yes □ No Nervousness/ Irritability
□ Yes □ No Stress/ Anxiety
□ Yes □ No Depression

Doctor's Signature _____