



Victoria Urological Associates, PA

New Patient Information



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Urology and
Genitourinary Surgery

Dear

Thank you for choosing Victoria Urological Associates, P.A., as your healthcare provider. Please find enclosed the following items which will help make your upcoming appointment go more efficiently:

- ◆ PATIENT INFORMATION SHEET
- ◆ NEW PATIENT MEDICAL HISTORY FORM
- ◆ MAP TO OUR OFFICE

Please complete all of the enclosed forms and bring them with you, along with your insurance cards, driver's license, and your co-pay/deductible to your scheduled appointment. If you have been referred to us by another physician, you will need to be sure that the following items get to our office prior to the time of your appointment.

- ◆ ANY PREVIOUS LAB RESULTS RELATED TO YOUR CURRENT PROBLEM
- ◆ MEDICAL RECORDS FROM YOUR PRIMARY CARE/REFERRING PHYSICIAN RELATED TO YOUR CONDITION
- ◆ X-RAYS, CT SCANS, MRI OR OTHER DIAGNOSTIC TESTS RELATED TO YOUR CURRENT PROBLEM

Our office will call 48-72 hours in advance to confirm your appointment. If you need to cancel or reschedule your appointment, please call our office during normal office hours (Monday through Friday, 8 a.m. to 5 p.m.) to provide us with at least 24 hours' notice so that we can give your appointment to another patient. **Failure to provide at least 24 hours' notice of cancellation prior to an appointment may result in a fee of \$25.00 being charged to the patient. Also, "no-shows" (patients who fail to show up for an appointment and do not notify our office beforehand) will be charged a \$25.00 fee.**

Please be aware that three consecutive "no-shows" will result in dismissal from the practice.

We strive to serve every patient at his/her appointment time. However, there are times when the physician is delayed due to an emergency, and we will make every effort to keep you informed if that occurs. **We do not refill pain medications or other medications after hours or on the weekends.**

Also be advised that we participate with only a select number of insurance companies. Be sure to verify whether or not we are on your insurance company's panel of providers through their customer service hotline.

We appreciate the opportunity to serve you and look forward to providing you with the highest quality of care. If you have any questions prior to your scheduled appointment, please feel free to contact our office Monday through Friday (8 a.m. to 5 p.m.) at (828) 254-8883.

Sincerely,

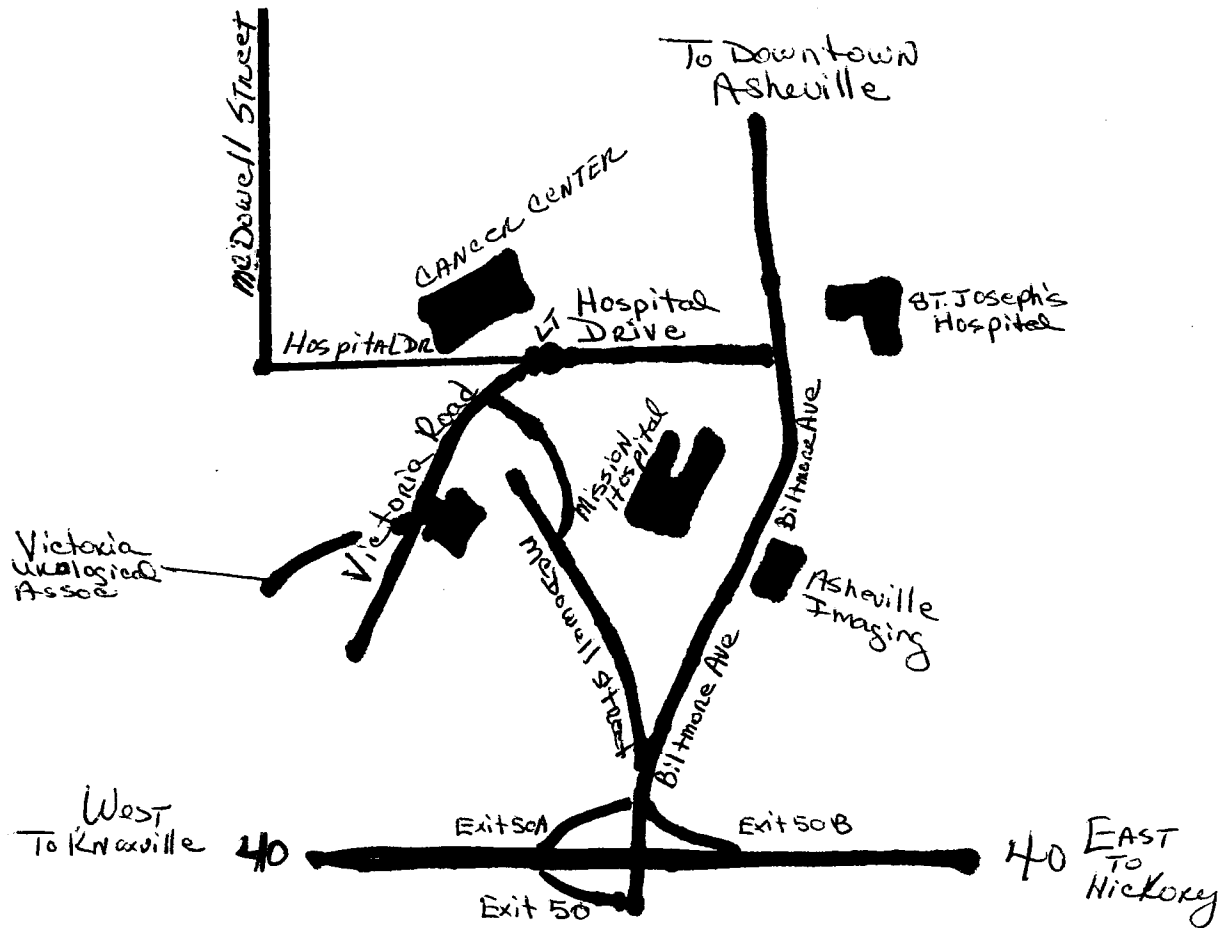
The Physicians & Staff of Victoria Urological Associates, P.A.



Urology and Genitourinary Surgery

100 Victoria Road
 Asheville, NC 28801
 Phone: (828) 254-8883

Kenny L. Simpkins, M.D., FACS • Karen R. Frye, M.D., FACS
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Victoria Urological Associates address: 100 Victoria Road, Asheville, NC 28801

Directions: From I-40: Take Exit 50 toward the Biltmore Estate. Drive toward the Biltmore House, but stay on Biltmore Avenue as if you are heading toward the downtown area. You will pass Asheville Imaging on your right, Mission Hospital on your left. You will pass under the Mahec Connector to the hospital then turn left at the next stop light onto Hospital Drive at the stop light at the new Cancer Center bear to the left to the three way stop signs go straight thru onto Victoria Road, our building is the first building on the left pass the 3 way stop. We are located diagonally across the street from Mahec Women's Center.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed.
IT IS YOUR RESPONSIBILITY TO REVIEW IT CAREFULLY.

LEGAL DUTY

Federal regulations developed under the Health Insurance Portability and Accountability Act require that the Victoria Urological Associates, P.A. (VUA) provide you with this "Notice of Privacy Practices" and how your Personal Health Information is handled.

UNDERSTANDING HEALTH INFORMATION

Each time you visit VUA, a record of the visit is made. Typically this record contains your history, symptoms, examination and test results, diagnoses, treatment and a plan for your future care or treatment. This information, often referred to as your health or medical record, serves as a:

Means of communication among health professionals who care for you and/or your child

It is a legal document that describes the care you received

Means by which you are identified for a third party payor so they may verify the services billed and provided

Tool in the training of health care professionals

Source of data for medical research

Source of data for public health officials

Understanding what is in your record and how your health information is used helps you to ensure it is correct, better understand how your health information is shared with others and allows you to make informed decisions when authorizing disclosure to others.

We will not use or disclose your health information without your authorization except as described in this notice.

HOW WE WILL USE OR DISCLOSE HEALTH INFORMATION

Treatment: We will use for health information for treatment. For example, one of our physicians recognizes that your condition requires hospitalization. In that example the physician would provide the necessary information to the hospital admission office.

Payment: We will use your health information for payment. For example, your insurance company requires precertification of a certain procedure you need to receive.

Health Care Operations: We will use your health information for regular health operations. For example, when our medical records are audited for accuracy and quality analysis.

Business Associates: There are some services provided in VUA through contacts with business associates. Examples include an accountant, attorney, consultants, and software vendor. We only disclose information that is necessary to perform the job we have requested and we require they protect the privacy of this information.

Communication with Family: Health professionals, using their best judgement, may disclose to a family member, other relative or close personal friend or any other person you identify, health information relevant to that person's involvement in your care or the care of your child or payment of services provided.

NOTICE OF PRIVACY PRACTICES – cont.

Research: If you are part of a clinical research trial we may disclose information to researchers when the research has been approved by an Institutional Review Board (IRB) or appropriate entity has approved the research and established methods to ensure privacy of the information.

Funeral Director/Coroner: We may disclose health information to funeral directors and coroners to carry out the duties consistent with the law.

Organ Procurement Organizations: Consistent with the law, we may disclose health information to organ procurement organizations for their designated services.

Marketing & Communication: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by state law governing workers compensation health care services.

Public Health: As required by law, we may disclose health information to public health officials charged with preventing or controlling disease, injury or disability. For example, we are required to report certain communicable diseases we may be treating you for.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. We may disclose information to correctional facilities as required by law.

Reports: We may disclose health information when directed by the appropriate federal oversight agency related to any complaints, surveys or requests.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of VUA, the information in the health record belongs to you or your child. You have the following rights:

You can request that we not use or disclose your information related to treatment, payment or health care operations. We ask that such requests be done in writing on a form we will provide. We will review each request individually. Although we will consider your request we are not obligated to honor it. We will inform you of our decision as quickly as possible.

You may request to be contacted by alternate means or at alternate locations. Such requests must be made in writing on a form we will provide. We will review each request individually and will attempt to honor all reasonable requests.

You may request to inspect a copy of your or your child's medical record. Such requests must be made in writing on a form we will provide. We will attempt to provide you with this information within thirty (30) days. We may charge a reasonable fee for copies.

If you believe that any information in the record is incorrect or if you believe important information is missing you may request that we correct or amend the information. Such requests must be made in writing on a form we will provide.

NOTICE OF PRIVACY PRACTICES – cont.

You may request a written accounting of disclosures we have made of your health information after April 14, 2003. This is limited to disclosures OTHER than treatment, payment or health care operations. We will maintain these records for six (6) years. We will respond to a request within sixty (60) days if possible. Such requests must be made in writing on a form we will provide. If you request an accounting more than once within a twelve (12) month period you will be charged a reasonable fee.

You have a right to a paper copy of this notice.

We must obtain a written authorization from you to disclose information other than treatment, payment, or health care operations. You have the right to revoke this authorization to the extent we have already used or disclosed the information.

CONCERNS AND COMPLAINTS

If you are concerned that VUA may have violated your privacy rights or if you disagree with any decision we have made regarding the use or disclosure of your information please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

For further information or complaints, contact the following person:

Office Manager
Victoria Urological Associates, P.A.
100 Victoria Road
Asheville, NC 28801

CHANGES TO THIS POLICY

VUA may change or update this policy at any time. When new changes are made a new “Notice of Privacy Practices” will be posted in the waiting room and on our website (www.VictoriaUrological.com) and will be provided at check-in at your next visit. You may request an updated copy of our notice at any time.

The following pages are to be filled out completely and brought to your upcoming appointment.

**VICTORIA UROLOGICAL ASSOCIATES, P.A.'S
NOTICE OF PRIVACY PRACTICES**

Victoria Urological Associates, P.A. (VUA) has provided me their "Notice of Privacy Practices" for my review.

I understand that the purpose of this notice is to inform me of my rights in regard to my protected health information (or in the case of a minor, my child's protected health information) and also the ways in which VUA may use that protected health information.

Signature of Patient or Legal Representative

_____/_____/_____
Date

**ACKNOWLEDGEMENT OF RECEIPT OF VICTORIA UROLOGICAL ASSOCIATES, P.A.'S
APPOINTMENT POLICIES**

Victoria Urological Associates, P.A. (VUA) has provided me their "Appointment Policies" for my review.

Signature of Patient or Legal Representative

_____/_____/_____
Date

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DEMOGRAPHICS

Patient Name: _____ **Also Known As:** _____
Weight ____ **Height** ____
Address: _____ **City/State/Zip:** _____
Date of Birth _____ **Age:** _____ **SSN#:** _____ **Sex:** _____
Referring Dr: _____ **Primary Dr.:** _____
Work Phone#: _____ **Home Phone#:** _____
Employer: _____ **Cell Phone #:** _____
Email: _____

Spouse's Name: _____ **Spouse's Date of Birth:** _____
Spouse's Work Phone#: _____ **Spouse's Mobile Phone#:** _____

PREFERRED PHARMACY NAME: _____
PREFERRED PHARMACY ADDRESS: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ *Contract #:* _____
Group #: _____
Secondary Insurance: _____ *Contract#:* _____
Group#: _____
Name of Insured: _____ *Certificate Suffix:* _____ *Relationship to patient:* _____

EMERGENCY CONTACT

Name: _____ *Phone#:* _____ *Relationship:* _____

PERMISSION TO RELEASE INFORMATION

I authorize Victoria Urological Associates, P.A. (VUA) to release all medical information requested by my health insurance carrier, Medicare or any other third party payers. I authorize VUA to release all medical information to my referring physician and my primary (family) physician. I authorize VUA to contact Medicare, BCBS, Medicaid, or any other health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct Medicare, BCBS, Medicaid or any other health plan administrator to release such information to VUA. I authorize access and release of confidential patient information by VUA for purposes of photocopying the information in response to properly authorized requests for copies of patients' medical records.

If you anticipate the need for anyone else (spouse, family members, close friend, etc) to have access to this information please complete the information below:

Name _____	Relationship _____
_____	_____
_____	_____

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I hereby assign to Victoria Urological Associates, P.A. (VUA) any Medicare, Medicaid, or any other third-party benefits available for health care services provided to me. I understand that VUA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to VUA, I agree to forward to VUA all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I also recognize that any co-pay amount my insurance requires me to pay is due at check-in and any deductibles, coinsurance, etc. will be due at check-out.

I understand that VUA agrees to file claims on all accepted benefit assignments in a timely manner. If such claims are not responded to by my insurance company in some fashion within thirty days then VUA will convert the remaining balance over to me and I will be responsible for the full charge.

The Patient and Responsible Party agree to be financially responsible to VUA regardless of coverage and coverage limits and that failure to make payment when due is the basis for legal action and may be subject to a 1.5% monthly finance charge. The Patient and Responsible Party agree that their financial obligation is joint and several and that VUA may pursue either or both parties for payment.

Patient (Agreement to Pay): _____ Date: _____

Guarantor (Agreement to Pay): _____ Date: _____

MISCELLANEOUS INFORMATION

How did you hear about Victoria Urological Associates, P.A.? (Please check all that apply)

- Your Primary Doctor Family Member Internet
- The Yellow Pages Friend Other _____

Patient Medical History-Male
Victoria Urological Associates, PA

Date: _____

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Referring Doctor: _____ Primary Care Doctor: _____

CHIEF COMPLAINT (Reason for visit): _____

UROLOGIC HISTORY (Check all that apply):

A. Urinary Symptoms

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Urgent need to urinate?
<input type="checkbox"/>	<input type="checkbox"/>	Frequently need to urinate? If so, how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Ever awakened from sleep to urinate (Nocturia)? If so, how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Strain to void
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting your urine stream
<input type="checkbox"/>	<input type="checkbox"/>	Weak urine stream
<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination
<input type="checkbox"/>	<input type="checkbox"/>	Pain/Pressure in lower abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Incomplete emptying of your bladder
<input type="checkbox"/>	<input type="checkbox"/>	Dribbling of urine after voiding
<input type="checkbox"/>	<input type="checkbox"/>	Blood in your urine
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence/leakage
<input type="checkbox"/>	<input type="checkbox"/>	History of urinary infections. If so, how many in the past year? _____
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease

B. Prostate

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Infections/Prostatitis
<input type="checkbox"/>	<input type="checkbox"/>	Prostate cancer
<input type="checkbox"/>	<input type="checkbox"/>	BPH (Enlarged Prostate = Non-cancerous)
<input type="checkbox"/>	<input type="checkbox"/>	Most Recent PSA Date: _____ Value: _____

C. Erectile Dysfunction

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Decreased sexual drive
<input type="checkbox"/>	<input type="checkbox"/>	Decreased rigidity/firmness
<input type="checkbox"/>	<input type="checkbox"/>	Inability to maintain an erection
<input type="checkbox"/>	<input type="checkbox"/>	Unsatisfactory for penetration
<input type="checkbox"/>	<input type="checkbox"/>	Erectile pain
<input type="checkbox"/>	<input type="checkbox"/>	Penile curvature
<input type="checkbox"/>	<input type="checkbox"/>	Absence of morning erections

MEDICAL HISTORY (Check all that you have been diagnosed with):

A. Pulmonary

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism
<input type="checkbox"/>	<input type="checkbox"/>	TB

F. Neurologic

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	MS
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury (Level _____)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke

B. Cardiovascular

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain w/ walking
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Prior angioplasty
<input type="checkbox"/>	<input type="checkbox"/>	Valvular Heart Disease

G. Gastrointestinal

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	<input type="checkbox"/>	Gastroesophageal Reflux
<input type="checkbox"/>	<input type="checkbox"/>	GI Bleed
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease (UC/Crohn's)
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis/Pancreatic Disease
<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcer Disease

C. Endocrine

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Hypo/Hyper Thyroidism

H. Renal Disease

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Renal Failure

D. Musculoskeletal

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis

I. Eyes

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma

E. Psychological

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

J. Hematologic/Immunologic

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Clotting Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, if so what type? _____
<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Transfusions
<input type="checkbox"/>	<input type="checkbox"/>	HIV/Aids

PAST SURGICAL HISTORY (List prior surgical procedures and approximate dates):

_____	_____
_____	_____
_____	_____
_____	_____

Preferred Pharmacy: Name and Location: _____

CURRENT MEDICATIONS & DOSAGES (Include Over-the-Counter & Herbal Medicines):

**if you filled out this information on the Patient Information Sheet you may skip this section*

_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____ Yes (list below) ____ No

**if you filled out this information on the Patient Information Sheet you may skip this section*

_____	_____
_____	_____
_____	_____

FAMILY HISTORY (Check all that your family members have been diagnosed with):

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Kidney Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Testicular Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

SOCIAL HISTORY (Check all that apply to you):

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	If so, What type? _____	Amount: _____	How long? _____
			If you answered yes and have quit give the date you quit _____		
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	If so, What type? _____	Amount: _____	How long? _____
			If you answered yes and have quit give the date you quit _____		
<input type="checkbox"/>	<input type="checkbox"/>	Illegal Drug Use	If so, What type? _____	Amount: _____	How long? _____
			If you answered yes and have quit give the date you quit _____		

Occupation: _____ Retired: ____ Yes ____ No

Marital Status: ____ Single ____ Widower

Married
 Divorced

Other

REVIEW OF SYSTEMS (Check beside all symptoms you are experiencing):

General

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Appetite changes
<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Medication changes

Cardiovascular

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Calf cramps
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing on exertion
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of extremities

Neurologic

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Decreased Memory
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Skin

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Bruising
<input type="checkbox"/>	<input type="checkbox"/>	New lesions

GI System

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Mass
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Black Tarry Stools
<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Nausea

Psychiatric

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Change in sleep pattern
<input type="checkbox"/>	<input type="checkbox"/>	Depression

HEENT

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision
<input type="checkbox"/>	<input type="checkbox"/>	Visual disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleed

GI System

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Mass
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Black Tarry Stools
<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Nausea

Endocrine

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Urination
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems

Neck

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Neck mass
<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands

Musculoskeletal

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness

Hematologic

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots

Respiratory

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Decreased exercise tolerance
<input type="checkbox"/>	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Bloody sputum

Reviewed by: _____

Date: _____