**Melissa R. Kinder, MD**

**Hand and Reconstructive Surgery Northwest**

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if injury, **date of injury**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Patient’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( last ) ( first ) ( middle )

Sex: \_\_\_\_\_\_\_\_\_\_\_\_ SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to leave message? **Y / N** OK to receive text appointment reminders? **Y / N**

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to email appointment reminders? **Y / N**

**If Minor,** name & relationship of parent or guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian’s DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Guardian’s SSN**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to Clinic by: (circle one) Hospital / E.R. (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information** Does the Patient have Medical Insurance? **Yes / No**

**On the Job Injury**? **Y / N** If so, Name of Employers Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Medical Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Melissa R. Kinder, M.D., or my insurance company to release any information required to process my claim(s).*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Authorized Persons signature Date**

**Confirmation of receipt of Office Procedures, Policies, Privacy Practices and Consents & Charge Card Policy**

Melissa R. Kinder, MD LLC

Hand and Reconstructive Surgery Northwest  
10121 SE Sunnyside Rd. Ste. 235 Clackamas, OR 97015

Office Procedures, Policies, Privacy Practices and Consents are available to view on our website [www.handsurgnw.com](http://www.handsurgnw.com). If you would like to receive a printed copy, please ask.

By signing below, I agree that I have reviewed and understand the information presented and have been given a copy of the office procedures, policies, privacy practices and consents for Melissa R. Kinder, MD LLC, D.B.A. Hand and Reconstructive Surgery Northwest.

I understand that receipt of this paperwork does not establish patient physician relationship and does not direct any responsibility to Dr. Kinder or any entity of Hand and Reconstructive Surgery Northwest.

Charge Card Policy: Should any charge card disputes arise, I authorize Hand and Reconstructive Surgery Northwest, Dr. Kinder and employees to discuss the charges and facts about my visits to the charge companies to resolve any issues.

Patient Name (please print) ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient sign if 18 years old or older)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- OR -

Patient Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Representative’s Authority (Mother, Father, Guardian…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Melissa R. Kinder, MD**

**Hand and Reconstructive Surgery Northwest**

PAST, FAMILY, SOCIAL, HEALTH HISTORY FORM

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAYS DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for allowing us to participate in your hand and reconstructive care. Please complete the following information to assist us in gathering information about your health history.

**HAND INJURY ONLY**

**Are you LEFT / RIGHT handed**

**Which hand is injured LEFT / RIGHT Have you ever injured this hand before YES / NO**

**HEALTH MAINTENANCE:**

**ALLERGIES** please list allergy & reaction**:**

Allergen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\* HEIGHT\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT\_\_\_\_\_\_\_\_\_\_\_\_\*\*\***

**PAST MEDICAL HISTORY:** ***Please check the box to the RIGHT for all that apply***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Arthritis (Rheumatoid) |  | Emphysema |  | Kidney Disease/Failure |  |
| Arthritis (Osteo) |  | Fibromyalgia |  | Kidney Stones |  |
| Asthma |  | Fractures (bones) |  | Osteoporosis |  |
| Bladder/Kidney Problems |  | GERD/Heartburn |  | Polymyalgia Rheumatica |  |
| Blood Clot (leg/arm) |  | Glaucoma |  | Pneumonia |  |
| Blood Clot (lung) |  | Gout |  | Prostate (enlargement) |  |
| Blood Transfusion |  | Heart Attack |  | Seizure/Epilepsy |  |
| COPD |  | Hepatitis- Type A |  | Skin Problems, Type: |  |
| Coronary Artery Disease |  | Hepatitis- Type B |  |  |  |
| Depression |  | Hepatitis- Type C |  | Sleep Apnea/CPAP/BIPAP |  |
| Diabetes Type I |  | Hepatitis- Other |  | Stomach Ulcer |  |
| Diabetes Type II (adult onset) |  | High Blood Pressure |  | Stroke |  |
| Cancer, Type: |  | High Cholesterol |  | Thyroid (nodule) |  |
|  |  | Hip Fracture |  | Thyroid (overactive) hyper |  |
| Other (list) |  | HIV/AIDS |  | Thyroid (underactive) hypo |  |
|  |  | Irritable Bowel Syndrome |  | Tuberculosis |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Melissa R. Kinder, MD**

**Hand and Reconstructive Surgery Northwest**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAYS DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY:**

Please list any surgeries or medical procedures that you have had.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:** Please check all that apply

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MEDICAL CONDITION** | **MOTHER** | **FATHER** | **SISTER** | **BROTHER** | **DAUGHTER** | **SON** |
| Alcoholism |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |
| Anesthesia problems |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |
| Bleeding problems |  |  |  |  |  |  |
| Cancer, type: |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |
| Diabetes, type I (childhood onset) |  |  |  |  |  |  |
| Diabetes, type II (adult onset) |  |  |  |  |  |  |
| Epilepsy (seizures) |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |
| Heart Attack (coronary artery disease) |  |  |  |  |  |  |
| High Blood Pressure (hypertension) |  |  |  |  |  |  |
| High Cholesterol (hyperlipidemia) |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |
| Lupus |  |  |  |  |  |  |
| Mitral Valve Prolapse |  |  |  |  |  |  |
| Osteoarthritis |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |
| Rheumatoid arthritis |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Thyroid disorder |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |

**Melissa R. Kinder, MD**

**Hand and Reconstructive Surgery Northwest**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAYS DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

**SUBSTANCES**

**Tobacco Use:** please circle one

Cigarettes Vape Cigar Pipe Chewing Tobacco

Never Smoker Current Smoker packs/day\_\_\_\_# of yrs \_\_\_\_\_ Former Smoker quit date: \_\_\_\_\_\_\_\_

**Alcohol Use:** please circle one

Do you drink alcohol? No / Yes number of drinks: \_\_\_\_\_\_\_\_ per week month year

**Drug Use:** please circle one

Do you use recreational drugs? No / Yes Type(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used needles? No / Yes

**Exercise:** please circle one

Do you exercise daily? No / Yes Weekly? No / Yes

What kind of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of work/job requirements: Sedentary Physical Labor Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Primary Care Physician? If so please tell us who and provide their phone number:

**Melissa R. Kinder, MD**

**Hand and Reconstructive Surgery Northwest**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAYS DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any current or recent prescription and over the counter medication you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS:**

**Please circle yes or no if you have recently experienced any of the following**

Fever **YES**  **NO**

Chest pain **YES NO**

Shortness of breath **YES NO**

Unexplained weight loss **YES NO**

Palpitations **YES NO**

Other musculoskeletal pain **YES NO**

Changes in appetite **YES NO**

Changes in bowel or bladder habits **YES NO**

Easily bruising or bleeding **YES NO**

History of blood clots **YES NO**