# LAS VEGAS CLINIC

## Patient Registration

### Patient Information

Name:_____ Date of Birth:_____
First MI Last

Mailing Address:_____ City:_____ State:_____ Zip:_____

Physical Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Social Security Number:_____ Gender: Male Female Ethnicity (optional):_____

Marital Status: Single / Married / Domestic Partnership / Divorced / Widowed Preferred Language (optional):_____

Employer:_____ Occupation:_____ Phone:_____

If married or domestic partnership, please provide: Spouse Name:_____ DOB:_____

Spouse's Employer:_____ Phone:_____

### Emergency Contact Information

Primary Contact:_____ Phone/Cell:_____ Relationship:_____

Secondary Contact:_____ Phone/Cell:_____ Relationship:_____

### Insurance/Billing Information

Will this visit be covered under Workers Compensation or Motor Vehicle/Liability Insurance? (Please Circle) Yes No

Do you have insurance? (Please Circle) Yes No If yes please complete insurance information below:

Primary Insurance Company:_____ ID#_____ Group #_____

Insured Name:_____ SSN:_____ DOB:_____

Relationship to Patient:_____ Deductible Amount:_____ Copay Amount:_____

Secondary Insurance Company:_____ ID#_____ Group #_____

Insured Name:_____ SSN:_____ DOB:_____

Relationship to Patient:_____ Deductible Amount:_____ Copay Amount:_____

How Did You Hear About Us? (Please Circle) Family or Friend / Referral / Other: _____

### Authorizations (HIPAA law makes it illegal for information to be released without the Patient's written authorization.)

I authorize Las Vegas Clinic to discuss billing/medical information with the individual(s) listed below:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

I authorize the individual(s) below to be present in the exam room while I am being treated and care is discussed:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____

If signed by someone other than the patient, please state relationship:_____

Las Vegas Clinic provides a patient portal to allow patients to view their records through a secure internet connection. Please provide an email address if you would like to be setup with access to your records.
Email address: _____

**Minor Patients (Under Age 18)**

The parent or guardian accompanying the minor to the office is responsible for any charges incurred and any payments due at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements for treatment have been made. In the case of multiple guardians (divorce or separation) the financial responsibility becomes that of the guardian who accompanies the patient to their appointment. If insurance coverage is under a guardian not present at the time of service, the information pertaining to that coverage (address, SSN, ID#, and group #) is required to bill the insurance.

Parent or Guardian Name: _____ Relationship: _____

Address (if different from above):_____City:_____State:_____Zip:_____

Home Phone: (if different from above)_____Cell Phone:_____

Social Security Number: _____DOB:_____Employer:_____

Other Parent or Guardian Name: _____Relationship:_____

Address (if different from above) _____City:_____State:_____Zip:_____

Home Phone (if different from above):_____Cell Phone: _____

Social Security Number: _____DOB:_____Employer:_____

**Notice of Privacy Practices/Authorization for Treatment/Billing/Collection Policy**

I understand that Las Vegas Clinic may share my health information for treatment, billing, and healthcare operations. I have been given a copy of the practice's Notice of Privacy Practices that describes how my health information is used and shared and have had an opportunity to read and ask questions. I understand that Las Vegas Clinic has the right to change this notice at any time. I may obtain a current copy by contacting the office or the Privacy Officer/Practice Manager.

I authorize treatment of the named patient contained in the registration sheet. I have been provided a copy of Las Vegas Clinic's financial policy which outlines their billing/collection procedures and I have had an opportunity to read and ask questions. I authorize all proceeds from insurance to be assigned to this office where applicable. I confirm that the information I have provided is true to the best of my knowledge.

I acknowledge that if I am 10 minutes late for my appointment the appointment may need to be rescheduled. Scheduled appointment times are generally adhered to, but no guarantee is implied. Unforeseen events may cause rescheduling or cancellation of your appointment. I also understand that if I need to cancel or reschedule an appointment or procedure, I must contact the office at least 24 hours prior to the appointment. If I fail to do so a charge of $50 may incur. If I no show for an appointment a charge of $50 may incur. I also acknowledge that if I no show for a testing appointment a $50 charge plus the cost of medication may incur.

I understand that it is my responsibility to contact my physician regarding any and all results after any testing is performed. I understand and acknowledge that I should request any prescription refills at the time of the office visit.

A monitoring safety net for you has been put into place to help you know when you are either due to see the physician, due for lab tests, or both. You will only receive enough medication to last you until your next physician exam and lab. Refill for medications will only be provided if you have fulfilled the lab and physician exam requirements. **I understand that most prescription refill requests that are initiated from a pharmacy will not be authorized. Prescript refill requests must come directly from the patient. Please do not assume that a pharmacy imitated request will be filled.**

Failure to follow physician's medical treatment or repeatedly missing appointments or procedures may result in the practice to discontinue medical care with Las Vegas Clinic.

Signature_____Date_____

If signed by someone other than the patient, please state relationship: _____

# LAS VEGAS CLINIC
## Financial Policy/Practice Agreement

Welcome to our practice. As you may know, health care is becoming more complicated every day. We would like to take this opportunity to advise you of your patient responsibilities and Las Vegas Clinic's financial policy. While many patients do not understand the billing of insurance and the processing of claims, it is a courtesy that we extend to our patients.

The following information outlines financial responsibilities related to payment for professional services provided by our physicians and staff. If you have any questions or concerns, please do not hesitate to ask a member of our staff for clarification. We believe a clear understanding of our financial policy is essential to our professional relationship. Additionally, your commitment to your account is just as significant as your participation with your health care.

**Financial Responsibility**

Las Vegas Clinic requires a copy of any insurance information and photo identification prior to treatment. This office will attempt to verify your benefits on each visit. It is our goal to provide you with the most accurate information in regard to authorizations, deductibles, co-pays, and co-insurance responsibilities. You, the patient or guardian, are ultimately responsible for all charges associated with your care regardless of insurance coverage. If you have insurance, please remember your insurance policy is a contract between you and your insurance company and that you have final responsibility for payment of your bill. For your convenience, our office accepts cash, check, Visa, and MasterCard. Please be advised you will receive a statement from this office as long as there is a balance on your account. A statement is not always a demand for patient payment. If your account balance falls in the 60 day or older category, noted at the bottom of your statement, please contact our billing office at 702-505-4230, extension 107.

**Self-Pay**

If you do not have insurance, payment in full is expected at the time of service. If you are unable to pay in full at the time of the service, arrangements will need to be made with our staff prior to treatment.

**Contracted Insurance**

Payment of any unmet deductible, co-insurance and/or co-pay is due at the time of service. You will receive a bill for any further portions due after your carrier processes your claim.

**Non-Contracted Insurance**

As a courtesy, we will bill **most** insurance companies. Payment of any unmet deductible, co-insurance, and/or co-pay is due at the time of service. You will receive a bill for any further portions due after your carrier processes your claim. Please be aware your insurance company may not cover all the services provided. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination of "usual and customary" rates by your insurance carrier.

**Medicare**

Las Vegas Clinic participates in the Medicare program; therefore, we will bill Medicare and accept assignment of benefits. If you have a secondary insurance plan, we will not require co-payment at the time of service. However, if you only have Medicare, we will collect 20% of the Medicare allowable at the time of service. Please be aware some services are not covered by Medicare and is the patient responsibility. You will receive a bill for any further portions due after Medicare processes your claim.

**Finance Charge/Collection Fees**

Las Vegas Clinic assesses finance charges on any account balance not paid within 90 days from the date of service. The finance charge will be computed at the rate of 1.5%. Any expense incurred collecting delinquent accounts is added to the account balance. A fee of $25 is charged for any returned checks or invalid credit card transactions.

**Appointment Cancellation and No Call No Show Fees**

Las Vegas Clinic requires 24 hour notice for appointment cancellations. Failure to provide adequate notice will result in the following fees being charged to your account- $50 for Physician appointments and $50 for procedures (EMG, EEG, etc).

Signature_____ Date_____

# LAS VEGAS CLINIC
# NOTICE OF PRIVACY PRACTICES
Effective 4/1/2014

**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 is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

**ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE** - You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

**OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION** – "Protected health information" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is required by law to do the following: (1) keep your protected health information private; (2) PRESENT TO YOU THIS Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the Notice currently in effect; and (4) post and make available to you any revised Notice. We reserve the right to revise this Notice and to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice's effective date is at the top of the first page and at the bottom of the last page.

**HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION** – Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

**Required Uses and Disclosures** – By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

**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 may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care. In emergencies, we will use and disclose your protected health information to provide the treatment you require.

**Payment** – Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require that your relevant protected health information be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

**Health Care Operations** – We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may 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 at your home telephone number to remind you of your next appointment and/or mail a postcard appointment reminder to your home address. We will share your protected health information with other persons or entities that perform various activities (for example, a transcription service) for our Practice. These business associates of our Practice are also required by law to protect your health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about our Practice and our services.

**Required by Law** – We may use or disclose your protected health information if law or regulations requires the use or disclosure.

**Public Health** – We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight** – We may disclose protected health information to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing review.

**Legal Proceedings** – We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

**Law Enforcement** – We may disclose protected health information for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.

**Coroner, Funeral Directors, and Organ Donations** – We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaver organ, eye or tissue donations.

**Research** – We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Threat to Health or Safety** – Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security – When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

**Worker's Compensation** – We may disclose your protected health information to comply with workers' compensation laws and similar government programs.

**Inmates** – We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

**Parental Access** – State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State and will make disclosures following such laws.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION** – In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following are examples in which your agreement or objection is required.

**Individuals Involved in Your Health Care** – Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION** – You may exercise the following rights by submitting a written request to our Privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.

Right to Inspect and Copy – You may inspect and/or obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

**Right to Request Restrictions** – You may ask us not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interest of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is needed to provide emergency treatment. You may ask us not to disclose certain information to your health plan. We must agree with that request only if the disclosure is not for the purpose of carrying out treatment and pertains solely to a health care item or service for which we have been paid out of pocket in full. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternative Confidential Communications – You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

**Right to Request Amendment** – If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

**Right to Accounting of Disclosure** – You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

**Rights Related to an Electronic Health Record** – If we maintain an electronic health record containing your protected health information, you have the right to obtain a copy of that information in an electronic format and you may choose to have us transmit such copy directly to a person or entity you designate, provided that your choice is clear, conspicuous, and specific. You may request that we provide you with an accounting of the disclosures we have made of your protected health information (including disclosures related to treatment, payment and health care operations) contained in an electronic health record for no more than 3 years prior to the date of your request (and depending on when we acquired an electronic health record).

**Other Rights**- You have the right to opt out of fundraising contacts. Las Vegas Clinic will not "sell" protected health information without the individual's authorization. You will be notified after a breach of unsecured protected health information.

**Right to Obtain a Copy of this Notice** – You may obtain a paper copy of this Notice from us by requesting one or view and down load it electronically at our Practice's website at www.lasvegasclinic.org.

**Special Protections** – This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, mental health information, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice.

**Complaints** – If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

**CONTACT INFORMATION** – Our Privacy Officer is our Practice Manager and can be contacted at this office or by calling our telephone number 907-745-2663. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices. You may also e-mail questions to our Privacy Officer at manager@lasvegasclinic.org.

Revised 4/1/2014

# Las Vegas Clinic

Jonathan McKinnon, MD *Neurology* Naya McKinnon, MD *Rheumatology*

351 N. Buffalo Drive, Suite B, Las Vegas NV 89145 Phone 702-505-4230 Fax 702-505-4231

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
## MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____

I authorize release
of my records TO: _____

FROM: _____

For the following reason:
___Continued care with another physician ___Legal reasons
___Personal copy of my treatment records ___Other

**Please note there is a 0.60 cent charge per page for printed personal copy of medical records. HIPAA compliant medical records request from doctors 'offices/lawyers/insurance/other third-party administrators do not have a charge to the patient.**

I request my records be provided in the following format (check one):

___Paper copy
___Faxed to #: _____
___Mailed to: _____

_____/_____ _____

**Signature of Patient/Guardian/Legal Representative** **Date** **ID Verification: Document and Number**

This authorization will automatically expire in twelve (12) months from the date signed. I understand that I may revoke this consent at any time and that revocation will not apply to information that has already been released as a result of this authorization. If I revoke this authorization, I must do so in writing and send it to the attention of the Privacy Officer. I understand that authorizing the disclosure of this health information is voluntary and that any disclosure of information carries with it the potential for an un-authorized re-disclosure and may no longer be protected by federal confidentiality rules. Las Vegas Clinic does not guarantee the completeness or accuracy of outside records; therefore, we will not be held responsible for the contents of the outside records that you receive.

FOR LAS VEGAS CLINIC USE ONLY

Records processed by Employee Initials and Date: _____

Records: ___Faxed ___Mailed

# LAS VEGAS CLINIC
## Medical History Form

In an effort to serve you better, we request you please provide us with the following information.

Name:_____ DOB:_____ Date:_____

Preferred Pharmacy:_____

Name of Primary Care Physician:_____

If you do not have a Primary Care Physician, would you like to establish primary care with Las Vegas Clinic? Yes No

What is the main medical condition or symptom you are being seen for today?

_____

Please list all prior and current medical conditions:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list prior surgeries and date(s):

_____ _____

_____ _____

_____ _____

_____ _____

Please list all allergies to medications: Are you allergic to latex? (Please circle) Yes No

_____ _____

_____ _____

_____ _____

Do you currently smoke cigarettes or use other forms of tobacco? (Please circle) Yes No

If yes, packs per day _____, total number of years you have smoked _____

If no to above question, have you ever smoke cigarettes or used other forms of tobacco? (Please circle) Yes No

If yes, number of years smoked _____ Average number of packs per day _____

Do you currently use, or have you previously used recreational drugs? (Please circle) Yes No

Marital status: (Please circle) Single Married Domestic Partnership Divorced Widowed

Occupation:_____ OR (circle) student unemployed disabled retired

What medical conditions are present in your family, especially parents, siblings and children?

_____

Any autoimmune disorder(s) in the family? (Please circle) Yes No

If Yes, please list disorder(s)_____

Any neurological disorder(s) in the family? (Please circle) Yes No

If Yes, please list disorder(s)_____

Has any member of your family been diagnosed with Cancer? (Please circle) Yes No

If yes, what type _____

Have you had a colonoscopy? (Please circle) Yes No If yes, date:_____

Have you had a flu shot? (Please circle) Yes No

**Female Patient:** Date of last pap? _____ or date of hysterectomy _____

Date of last mammogram? _____

**Male Patient:** Have you had a PSA test? (Please circle) Yes No If yes, date:_____

# Medication List

Name: _____ Date of Birth: _____

| Current Medications | Strength (mg) | # of times per day |
| --- | --- | --- |

Las Vegas Clinic
Review of Systems-Neurology

Name: _____ Date of Birth: _____

**Please check 'yes' or 'no' to any symptoms you are experiencing:**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Fevers | ☐ | ☐ | Bloody urine |
| ☐ | ☐ | Chills | ☐ | ☐ | Painful urination |
| ☐ | ☐ | Weight loss | ☐ | ☐ | Loss of control of urine |
| ☐ | ☐ | Weight gain | ☐ | ☐ | Joint pain |
| ☐ | ☐ | Night sweats | ☐ | ☐ | Back pain |
| ☐ | ☐ | Headaches | ☐ | ☐ | Depression |
| ☐ | ☐ | Visual loss | ☐ | ☐ | Anxiety |
| ☐ | ☐ | Double vision | ☐ | ☐ | Thoughts of suicide |
| ☐ | ☐ | Blurry vision | ☐ | ☐ | Have you ever been treated by a psychiatrist? |
| ☐ | ☐ | Hearing loss | ☐ | ☐ | Numbness |
| ☐ | ☐ | Trouble swallowing | ☐ | ☐ | Tingling |
| ☐ | ☐ | Trouble speaking | ☐ | ☐ | Weakness |
| ☐ | ☐ | Choking | ☐ | ☐ | Arm pain |
| ☐ | ☐ | Shortness of breath | ☐ | ☐ | Leg pain |
| ☐ | ☐ | Coughing | ☐ | ☐ | Trouble walking |
| ☐ | ☐ | Chest pain | ☐ | ☐ | Falls |
| ☐ | ☐ | Palpitations | ☐ | ☐ | Stroke |
| ☐ | ☐ | Swelling of extremities | ☐ | ☐ | Blood clots |
| ☐ | ☐ | Abdominal pain | ☐ | ☐ | Cancer or tumors (specify)_____ |
| ☐ | ☐ | Diarrhea | | | |
| ☐ | ☐ | Constipation | | | |
| ☐ | ☐ | Loss of control of bowels | | | |