HIPAA Notice of Privacy Practices

Effective May 6, 2019

THIS NOTICE DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to Premier Orthopaedic and Sports Medicine Associates, Ltd., and its employees (collectively "Premier"). Premier will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law and for the purposes described below.

We are required by the law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with the respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Premier. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent that a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing request to the Privacy Officer, Premier Orthopaedics, 3809 West Chester Pike, Suite 150, Newtown Square, PA 19073.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations and as described in this Notice unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: We will use and disclose your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc. They will also disclose your personal information to other providers who treat you.

Uses and Disclosures for Payment: We will use and disclose your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving clinical treatment and patient care.

Individuals Involved in Your Care: We may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or with payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with individuals you have not specifically designated. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that maybe involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment or information about your treatment or other health-related benefits and services that maybe of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Privacy Officer, Premier Orthopaedics, 3809 West Chester Pike, Suite 150, Newtown Square, PA 19073.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or Privacy Board that oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Prohibited Disclosures: We will never share your personal health information without your written authorization for marketing purposes, to sell the information, or if the personal health information includes psychotherapy notes.

Other Permitted Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities, such as required of disease, injury, birth and death, or required public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, or civil criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law to report wounds and injuries and crimes;
- To coroners and/or funeral directors' consistent with' law;
- If necessary, to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefits determinations.

Electronic communications: The sharing of your PHI for treatment, payment, and health care operations as described in this Notice may happen electronically. Electronic communications enable fast, secure access to your information for those participating in and coordinating your care to improve the overall quality of your health and prevent delays in treatment.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION

Confidential Communications: You have the right to request that we communication with you in a specific way (for example, by using a home or cell phone) or to send mail to a different address, and we will agree to all reasonable requests.

Access to Your Personal Health Information: You have the right to request an electronic or paper copy and/or to inspect much of the personal health information that we retain on your behalf. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your personal health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Personal Health Information: You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments, but we will give each request careful consideration. All amendment requests must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information: You have the right to receive a list (an "accounting") of certain disclosures made by us of your personal health information after April 14, 2003. You can ask for an accounting of the times we've shared your personal health information for six years prior to the date of your request. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you authorized us to make). Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment; or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. However, if you pay for a service or item out-of-pocket in full and request that we not share information about the service or item with your health plan or health insurer, we are required to agree to your request if the disclosure is for the purpose of payment or health care operations and is not required by law. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records

Right to Receive a Copy of this Notice: You have the right to receive a paper copy of this Notice, even if you have agreed to receive this Notice electronically.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing by sending a letter to the Office for Civil Rights, 200 Independence Avenue SW, Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint. For Further Information: If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer by email at privacy@premierortho.com, by telephone at 1-855-ORTHO24, or by writing to Privacy Officer, Privacy Officer, Premier Orthopaedics, 3809 West Chester Pike, Suite 150, Newtown Square, PA 19073.

Premier ORTHOPAEDICS

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered the **HIPAA Notice of Privacy Practices** for Premier Orthopaedic and Sports Medicine Associates, Ltd. ("Premier") and that I authorize the use and disclosure of health information about (patient's name) _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient/Representative Date

Premier
ORTHOPAEDICS

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT AND CONSENT TO TREATMENT

I hereby authorize Orthopaedic and Sports Medicine Associates, Ltd. ("Premier") and its physicians, practitioners and personnel to provide healthcare evaluation and treatment services to me.

I acknowledge and agree that I am responsible for payment of all charges for such services and items provided in connection with such services not fully paid by my insurance.

DIRECT PAYMENT: I authorize and direct my Insurance Carrier(s) to make payments for healthcare treatment, injections, supplies, and testing directly to Premier. I hereby authorize the submission of all information necessary to complete insurance claims for such items and services. These consents and authorizations shall be effective for me and my dependents. I agree that a copy of this authorization shall be valid as the original.

MEDICARE and MEDIGAP: I request that payment of authorized MEDICARE and MEDIGAP benefits be made either to me or on my behalf to the treating physician for services furnished by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents to my MEDIGAP insurer and any information needed to determine these benefits or the benefits payable for the related services.

_____ _____

Signature of Patient/Representative Date

Premier
ORTHOPAEDICS

CONSENT TO RECEIVE ELECTRONIC AND OTHER COMMUNICATIONS

I hereby agree to receive communications from, or on behalf of, Premier Orthopaedic and Sports Medicine Associates, Ltd. (collectively, "Premier"), including, without limitation, automated, autodialed, and prerecorded communications, either by text message, phone call, or e-mail, at the phone number and e-mail address provided. I understand that this consent is not a condition to my receiving services from Premier. I also understand that I can revoke this consent at any time by providing reasonable notice of such revocation to Premier.

_____ _____

Signature of Patient/Representative Date

Premier ORTHOPAEDICS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize Premier Orthopaedic & Sports Medicine Associates, LTD ("Covered Entity") to release the health information described below of myself or _____ to:

Recipient Name: _____
Relationship of Recipient to me or the individual named above _____
Recipient Address: _____
Recipient Phone #: _____

Specific Documents/Information I authorize to be released:

☐ All General Medical Initial _____
☐ Mental Health Initial _____
☐ Alcohol/Substance Abuse Initial_____
☐ Psychotherapy Notes Initial_____
☐ AIDS/HIV Initial_____
☐ Other (please specify, including dates of treatment and/or names of providers where appropriate):

Purpose of Disclosure (explain or indicate "at the request of the individual":

_____

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("Original HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH", and collectively with Original HIPAA, the "HIPAA Statute"), along with regulations promulgated by the Secretary of the Department of Health and Human Services under the HIPAA Statute, (collectively the "HIPAA Rules" and together with the HIPAA Statute, collectively, "HIPAA"), as well as any other applicable laws concerning the privacy and security of health information.

I understand that I have the right to revoke this Authorization, at any time prior to Covered Entity's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Covered Entity's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

Name of Covered Entity: Premier Orthopaedic and Sports Medicine Associates, LTD
Address: 3809 West Chester Pike, Suite 150
City, State Zip: Newtown Square, PA 19073
Attention: Privacy Officer

I understand that I am not required to sign this Authorization and that the Covered Entity may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires:

☐ One (1) year from date of authorization as set forth below.

☐ Upon Covered Entity's release of the information described above.

☐ _____ days after the Date of Authorization, as set forth below.

I hereby acknowledge receipt of a copy of this Authorization.

_____
Print Name

_____
Signature of Individual, Personal Representative or Parent

_____
Description of Parent's or Personal Representative's Authority

_____
Date of Authorization

Premier ORTHOPAEDICS

Name:_____ DOB:_____SS#_____ Today's Date: _____

Address:_____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail:_____

Race:_____ Ethnicity:_____ Gender: _____Preferred Language:_____

Primary Care Physician: _____ Referring Physician: _____

Primary Care Physician Address: _____

How did you hear about our practice? _____

Pharmacy Name and Phone: _____

Emergency Contact Name:_____ Emergency Contact Phone Number:_____

PLEASE GIVE ALL INSURANCE CARDS TO THE FRONT DESK

Primary Insurance

Type of Coverage: [ ] Health [ ] Workers Comp [ ] Auto Accident [ ] Slip & Fall

Date of Injury / Accident: _____If worker's comp, employment status: [ ] F/T [ ] P/T [ ] Self-employed

Employer's Name/Address/Zip/Phone: _____

_____

Insurance Company Name/Address/ Zip/Phone: _____

_____

Certification/I.D./Claim Number _____ Group Number: _____

Adjustor Name: _____ Adjustor Phone # _____

Subscriber Name: _____ Patient's Relationship: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Address: (if different than patient) _____

Subscriber S.S. # _____ Subscriber Date of Birth: _____

Secondary Insurance

Insurance Company Name/Address/Zip/Phone:_____

_____

Certification/I.D. Number: _____ Group Number: _____

Subscriber: _____ Patient's Relationship: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber S.S. # _____ Subscriber's Date of Birth: _____

Is patient responsible for bills? _____YES _____NO If **NO**, please provide the following:

Name of Guarantor: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____ Social Security #: _____

Relationship to patient: _____ Phone #: _____

Date:_____Signature of Patient, Parent or Guardian: _____

BRANDYWINE INSTITUTE OF ORTHOPAEDICS

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Start Here— Use black pen or pencil and mark the ● circles completely. The questions and your answers are for the current problem you are seeing the physician for today unless specifically asked about previous problems.

GENERAL PATIENT INFORMATION

Today's date

Please print your name.

Last Name

First Name MI

What is your age and date of birth?
Print numbers in the boxes.

Age Month Day Year

What is your sex? *Mark ● ONE circle*

○ Male ○ Female

What is your height and weight?
Print numbers in the boxes.

Height: ft. in. Weight: lbs

In the event you can't be reached, we need your permission to leave information on your voice mail system.

○ Yes, you can leave information pertaining to my medical care on my voice mail system.

○ No, you may not leave information pertaining to my medical care on my voice mail system.

How did you hear about our office?
Mark ● ONE circle.

○ ER ○ Physician ○ Friend
○ Internet ○ Newspaper ○ Radio
○ Phone book ○ Other—*Print other below.*

Who is your family physician?
Print name and phone number.

Who is the physician that referred you to our office?
Print name and phone number.

HISTORY OF CURRENT PROBLEM

1. What is your primary orthopaedic problem today? *Mark ● ONE circle*

○ Pain ○ Tingling ○ Instability
○ Stiffness ○ Numbness ○ Weakness
○ Swelling ○ Fracture
○ Other—*Print other below*

2. Where is the location of your primary orthopaedic problem? *Mark ● ONE circle*

○ Right side ○ Left side ○ Both sides

a. If both sides, which side bothers you the greatest? ○ Right ○ Left

3. What body part is involved with your primary orthopaedic problem?
Mark all that apply

○ Neck ○ Upper Back ○ Shoulder
○ Arm ○ Elbow ○ Forearm
○ Wrist ○ Hand ○ Thumb
○ Index Finger ○ Middle Finger ○ Ring Finger
○ Pinky ○ Mid Back ○ Low Back
○ Pelvis ○ Hip ○ Buttocks
○ Thigh ○ Knee ○ Lower Leg
○ Calf ○ Ankle ○ Foot
○ Toe ○ Other—*Print other below*

4. What is your dominant hand?

○ Right ○ Left ○ Ambidextrous

5. When was the onset of your current problem?

○ Unknown ○ Gradually
○ Suddenly, without injury
○ Suddenly, after an injury or accident
○ Gradually after an injury or accident
○ Other—*Print other below*

6. Did your symptoms begin after an injury or accident? *If Yes, complete below.*

○ After an injury (Do not include work or auto accidents) *Enter date of injury below*

○ After an accident (Do not include work or auto accidents) *Enter date of accident below*

CONTINUE on page 2.

7. Where did the injury take place?
Mark ● ONE circle

○ Home ○ School ○ Sports
○ Other—*Print other below*

a. Is your condition related to a motor vehicle accident?
○ No ○ Yes
• Date of the motor vehicle accident
• Where were you when the accident happened? ○ Driver ○ Passenger ○ Pedestrian
• If you were the passenger, where were you sitting?
○ Front Seat ○ Back Seat
• Were you wearing a seat belt?
○ No ○ Yes

b. Is your condition related to a work accident or injury?. ○ No ○ Yes
• Date of work injury or accident
• Name of the employer where the work injury or accident occurred.
• Date reported to your employer
• ○ Not reported

8. How did the injury or accident occur?
Please write complete sentences in the space below.

9. Have you been treated for this problem in the Emergency Room? ○ No ○ Yes
a. If yes, which Emergency room or Hospital were you treated.
b. What treatment did you receive.
c. Were you admitted to the hospital.
○ No ○ Yes

10. Have you been seen by another physician for this problem? ○ No ○ Yes
a. If yes, who was the treating physician?

11. Have you received Physical Therapy for this problem? ○ No ○ Yes
a. If yes, where did you receive your Physical Therapy treatment?
b. How long did you receive Physical Therapy?
○ < 1 month ○ 1 month
○ 2 months ○ 3-6 months
○ 7-12 months ○ Over 1 year

12. What medications are you taking for this problem?
○ Advil ○ Aleve ○ Arthrotec
○ Aspirin ○ Celebrex ○ Codeine
○ Daypro ○ Flexeril ○ Motrin
○ Naprosyn ○ Percocet ○ Skelaxin
○ Steroid Inj. ○ Tylenol ○ Vicodin
○ Voltaren ○ Other—*Print other below*

13. In the space provided, list all other medications you are taking including non-prescription medications Do not include the medications you have previously listed. ○ None

14. Indicate any past testing you've had done for this problem.
○ X-rays ○ MRI ○ Bone Scan
○ CAT Scan ○ Discogram ○ EMG
○ Ultrasound ○ Lab Tests
○ Other—*Print other below*

CONTINUE on page 3.

15. Have you had prior injuries of a similar nature? ○ No ○ Yes *If yes, explain below.*

16. Since the onset, what is the status of your symptoms?
○ Improved ○ Worsening
○ No change

17. How long have the symptoms been present?
Mark ● ONE circle. ○ Not sure

	1	2	3	4	5	6	7	8	9	10	11
Days	○	○	○	○	○	○					
Weeks	○	○	○	○							
Months	○	○	○	○	○	○	○	○	○	○	○
Years	○	○	○	○	○	○	○	○	○	○	○

18. On the scale below, mark the severity of your pain, 10 being the highest.
Mark ● ONE circle

	None	Mild			Moderate				Severe		
	0	1	2	3	4	5	6	7	8	9	10
Right	○	○	○	○	○	○	○	○	○	○	○
Left	○	○	○	○	○	○	○	○	○	○	○

19. How can the current problem be characterized?
○ Intermittent ○ Constant ○ Burning
○ Dull ○ Sharp ○ Stabbing
○ Throbbing ○ Aching ○ Cramping

20. What additional symptoms are you experiencing?
○ Chills ○ Fever ○ Numbness
○ Stiffness ○ Tingling ○ Weakness
○ Swelling ○ Instability ○ Fatigue
○ Loss of bowel control ○ Loss of feeling
○ Loss of bladder control ○ Sleep disturbance
○ Limit of motion ○ Difficulty walking
○ Radiation of pain ○ Headaches

21. Do the symptoms wake you up from sleep? ○ No ○ Yes

22. Symptoms improve with:
○ Rest ○ Activity ○ Medication
○ Ice/cold ○ Heat ○ Walking

23. Symptoms feel worse with:
○ Rest ○ Activity ○ Sitting
○ Ice/cold ○ Heat ○ Walking
○ Climbing Stairs

24. Are the symptoms worse during the day or night?
○ No difference ○ Day ○ Night

MEDICAL,PERSONAL,SOCIAL HISTORY

25. Do you have any allergies or reactions?
○ No known allergies.
○ Sulfa ○ Penicillin ○ Latex
○ Iodine dyes ○ Anesthesia ○ Codeine
○ Feathers ○ Eggs ○ Animals
○ Adhesive Tape ○ Environmental
○ Other—*Print other below*

26. Have you had any surgeries?
○ No ○ Yes
If yes, select from the list below.
○ Arthroscopy Knee ○ Arthroscopy Shoulder
○ Total Knee Replacement ○ Total Hip Replacement
○ Rotator Cuff Repair ○ Carpal Tunnel Release
○ Back Surgery ○ Neck Surgery
○ Appendectomy ○ Gall Bladder
○ Hysterectomy ○ Hernia
○ Malignancy ○ Bowel Surgery
○ Tonsilectomy
○ Other—*Print other below*

27. Indicate past medical conditions.
○ No significant medical history
○ Anemia ○ Asthma
○ Bleeding Disorder ○ Blood Transfusions
○ BPH/Prostate dis. ○ Bronchitis
○ Cancer ○ COPD
○ Coronary Artery dis ○ Depression
○ Diabetes ○ Elev. Cholesterol
○ Angina/Arrhythmia ○ Fibromyalgia
○ GERD ○ Glaucoma
○ Gout ○ Hypertension
○ Intestinal Disease ○ Kidney/Renal Disease
○ Liver dis./Hepatitis ○ Obesity
○ Osteoarthritis ○ Osteoporosis
○ Osteomyelitis ○ Peripheral Vascular
○ Phlebitis ○ Rheumatoid Arthritis
○ Seizures ○ Stomach Ulcers
○ Stroke/TIA/CVA ○ Thyroid Disease

CONTINUE on page 4.

28. Indicate your father's medical conditions.

- ○ No medical conditions
- ○ Arthritis ○ Cancer ○ Diabetes
- ○ Gout ○ Heart Disease ○ Stroke
- ○ TB ○ Hereditary Defects
- ○ High blood pressure

a. What is your father's health status?
○ Living ○ Deceased ○ Unknown

29. Indicate your mother's medical conditions.

- ○ No medical conditions
- ○ Arthritis ○ Cancer ○ Diabetes
- ○ Gout ○ Heart Disease ○ Stroke
- ○ TB ○ Hereditary Defects
- ○ High blood pressure

a. What is your mother's health status?
○ Living ○ Deceased ○ Unknown

30. Indicate your sibling's medical conditions.

- ○ No medical conditions
- ○ Arthritis ○ Cancer ○ Diabetes
- ○ Gout ○ Heart Disease ○ Stroke
- ○ TB ○ Hereditary Defects
- ○ High blood pressure

a. What is your sibling(s) health status?
○ All living ○ All deceased
○ Some living/some deceased
○ Unknown

31. What is your marital status?
Mark ● ONE circle

○ Single ○ Married ○ Divorced
○ Separated ○ Widowed

32. Do you live alone? ○ No ○ Yes

33. Are there stairs in your home?
○ No ○ Yes

34. What is your level of Education/School?

- ○ N/A ○ Current Student
- ○ Less than 12th grade ○ High School
- ○ Trade/Vocational ○ College
- ○ Professional

35. Do you drink caffeinated beverages?
Mark ● ONE circle ○ No ○ Yes

a. If yes, how many per day?
○ 1-2 cups/cans ○ 3-4 cups/cans
○ 5+ cups/cans

36. Do you drink alcohol? *Mark ● ONE circle*

- ○ No ○ Yes If yes, how frequently?
- ○ Rarely ○ Socially (2 to 3 per week)
- ○ Daily

37. Do you smoke tobacco?
Mark ● ONE circle ○ No ○ Yes

a. If yes, how many per day?
○ Less than one pack ○ One pack
○ Two packs ○ Three+ packs

b. How many years have you smoked?
○ 1-5 years ○ 6-10 years
○ 11-20 years ○ 20+ years

38. Do you have a history of recreational drug use? *Mark ● ONE circle*
○ No ○ Yes ○ Prior use

39.Do you take sleeping aids or sedatives?
Mark ● ONE circle ○ No ○ Yes
If yes, print type and number per week.

40. Select all problems you have had in the last 6 months?

○ Fevers	○ Sweats
○ Weight gain	○ Fatigue
○ Weight loss (unexpl.)	○ Hearing loss
○ Weight loss (planned)	○ Ringing in ears
○ Vision changes	○ Hoarseness
○ Trouble swallowing	○ Sore throat
○ Shortness of breath	○ Wheezing
○ Chronic cough	○ Leg cramps
○ High blood pressure	○ Palpitations
○ Irregular heartbeat	○ Chest pain
○ Diarrhea	○ Heartburn
○ Constipation	○ Nausea
○ Abdominal pain	○ Fracture
○ Vomiting	○ Bone pain
○ Other joint pain	○ Muscle spasms
○ Other muscle pain	○ Skin ulcers
○ Rashes	○ Hives
○ Loss of coordination	○ Weakness
○ Fainting	○ Numbness
○ Headaches/Migraine	○ Depression
○ Anxiety	○ Disoriented
○ Incontinence	○ Discharge
○ Burning urination	○ Freq urination
○ Difficulty urinating	○ Bleeding

What is your Pharmacy of choice?
Please provide name and location.

Please sign and date this form

Signature *Date*

Please return your completed form to the front desk.