

Mountain View Family Practice, PC
570 Baldwinville Road, Baldwinville, MA 1436
Telephone: (978) 939-2133 Fax: (833) 906-2588
Gretchen L. Kelley, MD

Kelly M. Clow, FNP-BC Sarah Gile, PA Alison Hietala, FNP-BC

PCP:

PATIENT INFORMATION

Patient's Last name:		Race/Ethnicity:		Marital Status (circle one)	
First name:		· Non-Hispanic or Latino		Single / Mar / Div / Sep / Wid	
Middle name:		· Hispanic or Latino			
		· Asian			
		· African American			
		· Other · Decline			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address:		Social Security No.:	Home Phone #:		
City:		State:	Zip:	Cell Phone #:	
Email Address:					

IF PATIENT UNDER THE AGE OF 18

Mother's Name or Legal Guardian	Relationship to patient:	Home phone #:	Cell phone #:
		()	()
Mother's Address if different from the child:			
Father's Name or Legal Guardian	Relationship to patient:	Home phone #:	Cell phone #:
		()	()
Father's Address if different from the child:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person Responsible for bill:	Birth Date:	Address (if different):	Home phone #:
	/ /		Cell phone #:
Name of Primary Insurance:			
Subscriber's name:	Birth date:	Group no.:	Policy #:
	/ /		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other
Name of secondary insurance (if applicable):			
Subscriber's name:	Birth date:	Group no.:	Policy no.:
	/ /		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient:	Home phone #:	Cell phone #:
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The above information is true to the best of my knowledge.

Patient/Guardian signature

Date

**ACKNOWLEDGEMENT OF PATIENT
BILLING RESPONSIBILITIES**

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, the patient is then responsible for the bill, interest and collection and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

I hereby authorize payment directly to Mountain View Family Practice for my charges.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Mountain View Family Practice to release any information which may include SUD acquired in the course of my examination or treatment to my insurance company in any form which may include but is not limited to electronically, fax or mail.

MEDICARE STATEMENT (if applicable):

- This claim will be submitted to Medicare for you by our office.
- Medicare may not cover some services which the patient will be responsible to pay. Such identified services include yearly physicals. In addition, you will be responsible for your yearly Medicare deductible & coinsurance if you do not subscribe to a supplemental policy that covers the deductible or coinsurance. We do not accept Medicare assignments.

Initial: _____ Self Other _____ (relationship)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Notice of Privacy Practices which includes February 15, 2026, addendum detailing how my PHI and SUD records may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Date:	Signature:	Relationship to Patient:
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ACKNOWLEDGEMENT OF RECEIPT OF PAYMENT POLICY

I have been presented with the Mountain View Family Practice, PC Payment Policy outlining their billing practices and my responsibilities for any non-covered balances.

Initial: _____ Self Other _____ (relationship)

Date:	Signature:	Relationship to Patient:
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Mountain View Family Practice, PC

Payment Policy

Thank you for choosing us as your healthcare provider(s). We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it and ask us any questions you may have.

1. **Insurance.** We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments, coinsurance, and deductibles.** Co-payments, coinsurance and deductibles must *be paid at the time of service by the patient or the person accompanying the patient.* A co-payment, coinsurance, and/or deductible are part of your contract with your insurance company. It is your insurance carrier, not Mountain View Family Practice, PC that assigns a co-payment, coinsurance, and or deductible as a patient responsibility. You will be billed if your insurance carrier notifies us at a later date that they have assigned a co-payment, coinsurance, and/or deductible for a service. Please note that Mountain View Family Practice, PC bills an additional charge for services provided on Federal holidays in accordance with correct coding guidelines. Failure on our part to collect co-payments, coinsurance, and deductibles from patients can be considered fraud. Please help us uphold the law by paying your co-payment, coinsurance, and/or deductible at each visit. Mountain View Family Practice, PC accepts payments in the form of cash, check, or major credit card.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit or if billed at a later date. Your physician is required by your insurance carrier to document the services provided. Please do not ask us to alter documentation for insurance coverage or insurance payment purposes.

4. **Uninsured (self-pay) visits.** Payment for all services not covered by insurance is required at the time of service. Mountain View Family Practice offers a 25% discount for payments received at time of service. If you live in Massachusetts, then you can apply for insurance online at www.MAhealthconnector.org or over the phone by calling 1(877) 623-6765. Heywood Hospital's Patient Financial Services department may also assist you in finding insurance. They can be reached at 978-630-6562 or 978-630-6550.

5. **Proof of insurance.** All patients must complete our Patient Registration form before seeing the provider. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance on your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be automatically billed to you.

8. **Non-payment.** If your account is over 30 days past due, then we will begin our collection processes. Our collection processes consists of a phone call to you if your balance is over \$50 and/or a series of the three letters. Please be aware that if a balance remains unpaid, then you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

9. **Bounced checks.** There will be a \$30.00 service charge added to your statement for any checks that are returned to us from the bank due to insufficient funds. You will be notified in writing and will be expected for provide payment in full.

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. You may speak with the office manager at the practice.

Payment Policy.doc
Revised 09/24/2019

HIPAA Notice of Privacy Practices

Effective as of March/1/2022

Mountain View Family Practice, PC
570 Baldwinville Rd
Baldwinville, MA 01436
978-939-2133

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations, except SUD records as explained on Feb 15, 2026 addendum, without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

You have the right to Choose someone to act for you: - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions about this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Provided By HCSI

Required Addendum to our NPP (Notice of Privacy Practices)

Effective as of February 15, 2026

Mountain View Family Practice, PC
570 Baldwinville Rd
Baldwinville, MA 01436
978-939-2133

Special Privacy Protections for Certain Health Information

We are **not primarily a substance use disorder (SUD) treatment program**. We may receive and maintain **SUD-related information incidentally** (e.g., referrals, history, meds, labs) and that information we maintain may be subject to additional federal privacy protections, including records related to the diagnosis, treatment, or referral for treatment of a substance use disorder. These records are protected by federal law (42 C.F.R. Part 2), which, in some cases, is more restrictive than HIPAA. When these stricter rules apply, we follow them.

How We May Use and Disclose Health Information

We may use and disclose your health information for treatment, payment, and health care operations. When information includes substance use disorder records, additional legal requirements may apply, including your written consent before using or disclosing that information.

Limits on Use of Substance Use Disorder Records

Federal law places **strict limits** on how substance use disorder records may be used or disclosed. Substance use disorder records cannot be used or disclosed to initiate or substantiate civil, criminal, administrative, or legislative proceedings without written consent or a qualifying court order.

Authorization and Consent

Certain uses and disclosures require written authorization. You may revoke authorization at any time by written request, except where already relied upon. If your health information includes substance use disorder records, your authorization may allow us to use and disclose that information for **treatment, payment, and health care operations**, as permitted by law.

Your Rights Regarding Your Health Information

You have rights to inspect, access, amend, request restrictions, request confidential communications, and receive an accounting of disclosures, as permitted by law.

Redisclosure Notice

If your health information is disclosed to another party, that party may be permitted to **redisclose** the information, and it may no longer be protected by HIPAA. However, **substance use disorder records** may continue to be protected by federal law even after disclosure, depending on the circumstances.

Public Health and De-Identified Information

We may disclose **de-identified health information** for public health, research, or health care operations purposes as permitted by law. De-identified information does not identify you and cannot reasonably be used to identify you.

Fundraising Communications

We may contact you for **fundraising purposes**. You have the right to **opt out** of receiving fundraising communications at any time. Your decision to opt out will **not affect your access to care**.

Complaints and Enforcement

If you believe your privacy rights have been violated, you may file a complaint with us or with the **U.S. Department of Health and Human Services**. You will not be retaliated against for filing a complaint.

Changes to This Notice

We reserve the right to change this Notice of Privacy Practices at any time. Any changes will apply to all health information we maintain. The current version of this Notice will be available upon request and on our website.



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Gretchen L. Kelley, MD Kelly M. Clow, FNP-BC Sarah Gile, PA Alison Hietala, FNP-BC

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI)

PATIENT NAME: _____
PATIENT DOB: _____
ADDRESS: _____
PHONE: _____

Information to be Used or Disclosed:

The information covered by this authorization includes:

<input type="checkbox"/> ALL RECORDS	<input type="checkbox"/> *HIV/AIDS _____
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> *MENTAL HEALTH/PSYCHIATRIC _____
<input type="checkbox"/> X-RAY REPORTS	<input type="checkbox"/> *ALCOHOL/DRUG INFORMATION _____
<input type="checkbox"/> LAB REPORTS	<input type="checkbox"/> *ABORTION _____
<input type="checkbox"/> IMMUNIZATIONS	<input type="checkbox"/> *SEXUAL ASSAULT _____
<input type="checkbox"/> OTHER(PLEASE SPECIFY)	<input type="checkbox"/> *OTHER(PLEASE SPECIFY) _____

*INDICATES PHI THAT INITIALS ARE REQUIRED IN ORDER TO RELEASE THIS INFORMATION

Purpose of the Disclosure:

<input type="checkbox"/> TRANSFER TO NEW PHYSICIAN
<input type="checkbox"/> PERSONAL USE
<input type="checkbox"/> MEDICAL TREATMENT
<input type="checkbox"/> OTHER (PLEASE SPECIFY)

Persons Authorized to Disclose the Above Information:

(Name of person or organization)

Persons to Whom Information May Be Disclosed:

(Name of person or organization)

I understand that if the person (s) and/or organization listed above are not healthcare organizations, health plans or healthcare clearing houses (that must follow the federal privacy stands), the health information disclosed as a result of this authorization may no longer be protected by the federal privacy act and my health information may be redisclosed without obtaining my authorization.

Expiration Date of Authorization:

This authorization is effective through (check one) ____/____/____ or NO Expiration, remains in effect until revoked by the patient in writing.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our office. You should submit your written revocation to the HIPAA Compliance Officer.

Rights/Potential for Re-disclosure

I understand I have the right to inspect or copy my health information that I authorized to be disclosed with this form. I can expect to have my health information available to me by calling Mountain View Family Practice, PC and arranging a time to do so. I understand that there may be a fee to copy my information and that it could take up to 30 days to do so. I understand that if I agree to sign this form, which I am not required to do, I have a right to receive a copy of this form. I understand that I am under no obligation to sign this authorization and that the person (s) and or organization listed on this form will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

I have completed, reviewed and understand the information contained in this form. I agree to the release of this information.

Signature of Patient/Parent/Legal Guardian: _____ Date _____

Relationship of Patient (if signature other than patient, i.e. Parent/Legal Guardian) _____

Witness: _____ Date _____

MOUNTAIN VIEW FAMILY PRACTICE, PC
 570 BALDWINVILLE RD
 BALDWINVILLE, MA 01436
 PHONE: 978-939-2133
 FAX: 978-939-8580

NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____
 Birth Date: _____ Age: _____

ALLERGIES NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS <i>(Please list ALL)</i>	DOSE <i>(Mg., pill, etc.)</i>	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or Tdap:	Last Pnuemovax (Pneumonia):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (Shingles):	

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type: _____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type: _____)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (kidney) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE (specify left/right)	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

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OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N (If no sexual history, please continue to Exercise)	
Sexual partner(s) is/are/have been: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birth control method: <input type="checkbox"/> None <input type="checkbox"/> Condom <input type="checkbox"/> Pill/Ring/Patch/Inj/IUD <input type="checkbox"/> Vasectomy		
EXERCISE	Do you exercise regularly? Y N (If you answered no, please move to Sleep)	
What kind of exercise?		Duration: How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night (or during the day, if working night shift)?	
DIET	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other: _____		
Other: _____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____ DOB: _____

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REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY

CONSTITUTION		CARDIOVASCULAR		SKIN	
Activity change		Chest pain		Color change	
Appetite change		Leg swelling		Pallor	
Chills		Palpitations		Rash	
Diaphoresis		Gastrointestinal		Wound	
Fatigue		Abdominal distention		ALLERGY/IMMUNO	
Fever		Abdominal pain		Environmental allergies	
Unexpected weight change		Anal bleeding		Food allergies	
HEAD, EAR, NOSE & THROAT		Blood in stool		Immunocompromised	
Congestion		Constipation		NEUROLOGICAL	
Dental problem		Diarrhea		Dizziness	
Drooling		Nausea		Facial asymmetry	
Ear discharge		Rectal pain		Headaches	
Ear pain		Vomiting		Light-headedness	
Facial swelling		ENDOCRINE		Numbness	
Hearing loss		Cold intolerance		Seizures	
Mouth sores		Heat intolerance		Speech difficulty	
Nosebleeds		Polydipsia		Syncope	
Postnasal drip		Polyphagia		Tremors	
Rhinorrhea		Polyuria		Weakness	
Sinus pressure		Genitourinary		HEMATOLOGIC	
Sneezing		Difficulty urinating		Adenopathy	
Sore throat		Dysuria		Bruises/bleeds easily	
Tinnitus		Enuresis		PSYCHIATRIC	
Trouble swallowing		Flank pain		Agitation	
Voice change		Frequency		Behavior problem	
EYES		Genital sore		Confusion	
Eye discharge		Hematuria		Decreased concentration	
Eye itching		Penile discharge		Dysphoric mood	
Eye pain		Penile pain		Hallucinations	
Eye redness		Penile swelling		Hyperactive	
Photophobia		Scrotal swelling		Nervous/anxious	
Visual disturbance		Testicular pain		Self-injury	
RESPIRATORY		Urgency		Sleep disturbance	
Apnea		Urine decreased		Suicidal ideas	
Chest tightness		MUSCULAR			
Choking		Arthralgias			
Cough		Back pain			
Shortness of breath		Gait problems			
Stridor		Joint swelling			
Wheezing		Myalgias			
		Neck pain			
		Neck stiffness			

Patient Name: _____

DOB: _____