



## Patient Registration Form

Name \_\_\_\_\_  

Last
First
Middle

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

City
State
Zip

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please Check:** Sex:  Male  Female  
 Marital Status:  Single  Married  Divorced  Widowed

Social Security #: \_\_\_\_\_ Employer/School: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Spouse Name or Parent/Guardian if Patient is under 18:** \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Primary #: \_\_\_\_\_ Address: \_\_\_\_\_

**Insurance Information** (Please present Insurance Card at time of Check-In)

Insurance Information	Primary	Secondary
Name of Insurance Company		
Insurance ID #		
Group ID #		
Name of Policyholder/Subscriber		
DOB of Policyholder/Subscriber		
SSN of Policyholder/Subscriber		

Email: \_\_\_\_\_ Would you like Patient Portal?  Yes  No

Ok to Leave a Message at: Home and/or Cell  
 Brief  Brief  
 Extended  Extended

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO 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.**

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I request the payment of authorized Medicare/other Insurance Company benefits be made to me or on my behalf to Wilmington Endocrinology, PA for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128D of the Social Security Act & 31 USC 3801-3812 provides penalties for withholding this information.)

**My signature below gives my acknowledgement and agreement to a \$5.00 per month billing statement fee commencing after 60 days.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Wilmington Endocrinology for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wilmington Endocrinology. I understand that diagnosis or treatment of me by Ghobad Azizi, MD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Wilmington Endocrinology is not required to agree to the restrictions that I may request, the restriction is binding on Wilmington Endocrinology and Ghobad Azizi, MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that Ghobad Azizi, MD or Wilmington Endocrinology has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Wilmington Endocrinology's Notice of Privacy Practices prior to signing this document. Wilmington Endocrinology's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Wilmington Endocrinology. The Notice of Privacy Practices for them is also provided in the waiting area. This Notice of Privacy Practices also describes my rights and Wilmington Endocrinology's duties with respect to my protected health information.

Wilmington Endocrinology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority



## **Wilmington Endocrinology Insurance Policy**

Welcome to our practice. We are committed to providing you with the best possible care and we are open to discussing our professional fees with you at any time.

Currently, we are participating with most major insurance companies. However, all deductibles, co-payments, and/or co-insurance payments are due at time of service. If your insurance has a percentage co-insurance, please be prepared to make this payment at the time of service.

Insurance is a contract between you and your insurance company. We cannot become involved in disagreements between you and the insurance company regarding deductibles, co-payments, covered charges, etc.

In order for insurance claims to be filed promptly it is your responsibility to inform our office of any changes to your insurance. If you do not provide correct insurance information to the office, this may result in claims being denied for timely filing. If a claim is denied for timely filing for this reason, you will be responsible for all charges.

## **Wilmington Endocrinology Financial Policy**

Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions.

As per above payment is due at time of service. We accept cash, checks, Visa, MasterCard, and Discover.

Returned checks will be subject to additional collection fees. A \$50 charge may also be assessed for no show appointments and same day cancellations.

Self Pay Patients must pay entire discounted amount on the date of service. Patients with past due balances must pay entire balance plus today's charges.

We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Payment arrangements must be made prior to treatment.

Thank you for understanding our financial and insurance policies. If you have any questions about the above information, do not hesitate to ask us. We are here to assist you.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Upon request a copy of this agreement will be given to the patient.



## Appointment Cancellation Policy

At Wilmington Endocrinology we strive to render excellent medical care to you and the rest of our patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

We request that you please give our office 24 hours notice in the event that you need to reschedule your appointment. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointment (NO SHOW). A \$50 fee may be charged to you for the 2nd missed appointment. This fee must be paid before another appointment will be scheduled. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and will be asked to leave the practice.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment may be cancelled. New patient appointments cannot be rescheduled, as they often involve authorizations that are valid only for a specific amount of time.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

# History Questionnaire

Completed by: (Staff) (Patient) (Physician) on: \_\_\_\_\_

## Please Circle and Fill In Blanks

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: Retired Active: \_\_\_\_\_

### Do you: (Please Circle Yes or No and Explain if Yes)

Live w/ Others: No Yes Who: \_\_\_\_\_  
Have Children: No Yes # Living: \_\_\_\_\_ # Deceased: \_\_\_\_\_ Cause: \_\_\_\_\_  
Get Exercise: No Yes Hours per Week: \_\_\_\_\_  
Use Illegal Drugs: No Yes \_\_\_\_\_  
Use Alcohol: No Yes Ounces per Day/Week: \_\_\_\_\_  
Smoke: No Yes PPD: \_\_\_\_\_ Stopped: \_\_\_\_\_

### Have you ever had:

Surgery: No Yes Date: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Reason: \_\_\_\_\_  
Date: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Reason: \_\_\_\_\_  
Date: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Reason: \_\_\_\_\_

Metal in  
Your Body: No Yes Location: \_\_\_\_\_  
Heart  
Valves/Stents: No Yes Location: \_\_\_\_\_

Blood Transfusion: No Yes Date: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Reason: \_\_\_\_\_  
An Illness: No Yes Date: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Reason: \_\_\_\_\_

Head & Neck  
Radiation: No Yes Date: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Reason: \_\_\_\_\_

Are you  
claustrophobic? No Yes

### Problems for which you have seen a physician or have been treated for:

Diabetes:	No	Yes	<b>Autoimmune Diseases:</b>	
Malignancy (Cancer):	No	Yes	Arthritis (Osteo):	No Yes
Tumor/Lesion:	No	Yes	Rheumatoid Arthritis:	No Yes
COPD:	No	Yes	Lupus or "SLE":	No Yes
Blood Pressure:	No	Yes	Gout:	No Yes
Heart Problem:	No	Yes	Psoriasis:	No Yes
Infections:	No	Yes	Sjogren's Syndrome:	No Yes
Pain:	No	Yes	Other: _____	
Nerves/Anxiety:	No	Yes		
Thyroid:	No	Yes		
Other: _____				

**Do any of your blood relatives have any of the following diseases? Do any other medical problems run in the family?**

Diabetes: No Yes Type: \_\_\_\_\_  
 Cancer: No Yes Location: \_\_\_\_\_  
 Tumor/Lesion: No Yes Location: \_\_\_\_\_  
 Thyroid Disease: No Yes Type: \_\_\_\_\_  
 Stroke: No Yes Date: \_\_\_\_\_  
 Tuberculosis: No Yes \_\_\_\_\_  
 High Blood Pressure: No Yes \_\_\_\_\_  
 Heart Problem: No Yes Type: \_\_\_\_\_  
 Other Health Problems: No Yes \_\_\_\_\_

**Please Circle and Fill in the Blank if Applicable:**

Your Father: Living Deceased \_\_\_\_/\_\_\_\_/\_\_\_\_ Cause: \_\_\_\_\_  
 Your Mother: Living Deceased \_\_\_\_/\_\_\_\_/\_\_\_\_ Cause: \_\_\_\_\_  
 Your Brother(s): Living Deceased \_\_\_\_/\_\_\_\_/\_\_\_\_ Cause: \_\_\_\_\_  
 Your Sister(s): Living Deceased \_\_\_\_/\_\_\_\_/\_\_\_\_ Cause: \_\_\_\_\_

**Please List all Medications and Supplements:**

Name of Medication:	Strength:	Frequency:	Currently Taking:
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes

**Please Answer and Fill in the Blank if Applicable:**

Any Allergies: No Yes \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



### Authorization for Release of Information

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Wilmington Endocrinology, PA is authorized to release protected health information about the above named patient to entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Please Check the Following:

Entity to Receive Information:	Description of Information to be Released:
<input type="checkbox"/> Voice Mail <input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Financial: _____ <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Spouse Name: _____	<input type="checkbox"/> Financial: _____ <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Parent/Guardian Name: _____	<input type="checkbox"/> Financial: _____ <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Other Name: _____	<input type="checkbox"/> Financial: _____ <input type="checkbox"/> Medical as follows: _____ _____

#### Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.*

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority  
(attach necessary documentation)



## Patient Extra Demographics

Patient Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_

To comply with government standards relating to our electronic health record software we are required to capture certain demographic elements. Please help us so our records will be complete by answering the following questions. Thank you.

### Race?

<input type="checkbox"/>	American Indian or Alaska Native
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Native Hawaiian
<input type="checkbox"/>	Black or African American
<input type="checkbox"/>	White/Caucasian
<input type="checkbox"/>	Hispanic or Latino
<input type="checkbox"/>	Other Race
<input type="checkbox"/>	Other Pacific Islander
<input type="checkbox"/>	Prefer not to report

### Ethnicity?

<input type="checkbox"/>	Hispanic
<input type="checkbox"/>	Non-Hispanic
<input type="checkbox"/>	Prefer not to report

### Preferred language?

<input type="checkbox"/>	English
<input type="checkbox"/>	Other
<input type="checkbox"/>	Indian (includes Hindi & Tamil)
<input type="checkbox"/>	Spanish
<input type="checkbox"/>	Russian

### Smoking Status

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Are you a smoker?  Yes  No

#### Please check one

<input type="checkbox"/>	Current Smoker
<input type="checkbox"/>	Former Smoker
<input type="checkbox"/>	Never Smoker
<input type="checkbox"/>	Current Every Day Smoker
<input type="checkbox"/>	Current Some Day Smoker
<input type="checkbox"/>	Smoker, Current status
<input type="checkbox"/>	Unknown if ever smoked

Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## Bubble Sheet Instructions

By filling out the following bubble sheets our clinical staff will be able to better assess your care. Please answer all questions, do not leave any blanks.

Please fill in each bubble completely using black ink or number 2 pencil. Do not mark outside of the bubble.

DO NOT WRITE ON FORM OR MARK OUTSIDE OF BUBBLE.

**Incomplete bubbles, x's or checks will NOT be recognized by the system.**

Correct marks: ●

Incorrect marks: ◐ ◑ ☺ ∅ X ✓



**General**

- |                          |                           |                          |                           |
|--------------------------|---------------------------|--------------------------|---------------------------|
| Loss of appetite         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Weight loss              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Weight gain              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Fatigue                  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Loss of height           | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Insomnia                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Inability to lose weight | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

**Thyroid/Neck**

- |                       |                           |                          |                           |
|-----------------------|---------------------------|--------------------------|---------------------------|
| Enlarged thyroid      | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Palpable neck mass    | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Choking sensation     | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Voice weakness        | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Hoarseness            | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Difficulty swallowing | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Pressure in neck      | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Neck pain             | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

**Eye**

- |                  |                           |                          |                           |
|------------------|---------------------------|--------------------------|---------------------------|
| Loss of vision   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Decreased vision | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Double vision    | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Bulging eyes     | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Dry eyes         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

**Cardiac**

- |                        |                           |                          |                           |
|------------------------|---------------------------|--------------------------|---------------------------|
| Chest pain or pressure | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Palpitations           | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Leg swelling           | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

**Lungs**

- |                     |                           |                          |                           |
|---------------------|---------------------------|--------------------------|---------------------------|
| Shortness of breath | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Cough               | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Wheezing            | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

**Gastrointestinal**

- |                |                           |                          |                           |
|----------------|---------------------------|--------------------------|---------------------------|
| Diarrhea       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Vomiting       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Constipation   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Nausea         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Heartburn      | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Abdominal pain | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_



### Gynecological

- |                   |                           |                          |                           |
|-------------------|---------------------------|--------------------------|---------------------------|
| Pregnant          | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Hot flashes       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Absence of menses | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Postmenopausal    | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Breast tenderness | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Infertility       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Heavy menses      | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Regular menses    | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

### Endocrinology

- |                               |                           |                          |                           |
|-------------------------------|---------------------------|--------------------------|---------------------------|
| Excessive thirst              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Excessive urination           | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Sensitive to hot temperature  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Sensitive to cold temperature | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Cold hands or feet            | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Excessive sweating            | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

### Musculoskeletal

- |                         |                           |                          |                           |
|-------------------------|---------------------------|--------------------------|---------------------------|
| Joint stiffness         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Joint pain              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Back pain               | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Fracture                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Muscle cramping         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Muscle weakness         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Decrease in muscle mass | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Muscle Pain             | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

### Neurologic

- |                                 |                           |                          |                           |
|---------------------------------|---------------------------|--------------------------|---------------------------|
| Frequent headache               | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Tingling                        | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Tremor                          | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Numbness                        | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Migraines                       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Burning pain in feet            | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Burning pain in hands           | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Piercing/stabbing pains in feet | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Vertigo                         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Pain in lower back              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Weakness                        | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Dizziness                       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_



**Dermatology**

- |                       |                           |                          |                           |
|-----------------------|---------------------------|--------------------------|---------------------------|
| Excessive hair growth | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Excessive dry skin    | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Hair loss             | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Acne                  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Itching               | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Loss of pigmentation  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Rash                  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

**Psychiatric**

- |                    |                           |                          |                           |
|--------------------|---------------------------|--------------------------|---------------------------|
| Depression         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| High stress level  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Sleep disturbances | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Eating disorder    | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Mood swings        | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Anxiety            | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_