Lomibao
RHEUMATOLOGY & WELLNESS CARE

Patient Information

Last_____ First_____ M_____

DOB_____/_____/_____ Sex circle one: Female Male SS#_____-_____-_____

Cell Phone_____ Home Phone_____

Email_____

Address_____
Street City State Zip

Emergency/Alternate Contact

Last_____ First_____ M_____

Relation_____ Phone_____ Email_____

Employer ☐ check here if not employed

Name_____ Phone_____

Address_____
Street City State Zip

Primary Insurance

Name_____ Phone_____

Group_____ ID_____

Address_____
Street City State Zip

Primary Insured ☐ check here if same as patient

Last_____ First_____ M_____

DOB_____/_____/_____ Relationship to Patient_____

Phone_____ Email_____

Address_____
Street City State Zip

Secondary Insurance ☐ check here if none

Name_____ Phone_____

Group_____ ID_____

Address_____
Street City State Zip

7700 Lakeview Pkwy Suite 300A
Rowlett, TX 75088
Phone: 469-207-1269
Fax: 469-646-8804

Last_____ First_____ DOB_____/_____/_____

Secondary Insured ☐ check here if same as patient ☐ check here if same as primary insured

Last_____ First_____ M_____

DOB_____/_____/_____ Relationship to Patient_____

Phone_____ Email_____

Address_____
Street City State Zip

Referring Provider

Last_____ First_____

Phone_____ Fax_____

Address_____
Street City State Zip

Primary Care Provider ☐ check here if same as referring provider

Last_____ First_____

Phone_____ Fax_____

Address_____
Street City State Zip

Pharmacy - Local

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Pharmacy - Mail Order ☐ check here if none

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Demographics - Please circle one of each of the following:

Marital Status	Race	Ethnicity	Language
Annulled	American Indian/Alaskan Native	Declined to specify	English
Divorced	Asian	Hispanic or Latino	Other
Domestic Partner	Black or African-American	Not Hispanic or Latino	Spanish
Legally Separated	Declined to specify	Other	
Married	Multiracial more than one race		
Single	Native Hawaiian or Other Pacific Islander		
Widowed	White		

Last_____ First_____ DOB_____/_____/_____

Financial Policy, Billing Procedures, Card on File Policy

Lomibao Rheumatology & Wellness Care, PLLC is participating in-network with Medicare and many commercial insurance carriers. If you have coverage with Medicare and/or one of the commercial insurance carriers that we participate in, we will file your claim directly to your insurance carrier or Medicare for reimbursement.

As a courtesy, Lomibao Rheumatology & Wellness Care, PLLC will contact your insurance carrier to verify your benefits and/or necessary authorizations prior to your visit. Please be aware, this is only “a QUOTE of Benefits/Authorizations.” We cannot guarantee reimbursement or verify that definite eligibility of benefits conveyed to us, or to you, by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, and exclusions of the member’s contract at the time of service. In the event that your insurance provider does not in fact cover services rendered, you will remain responsible for the charges.

If your insurance carrier requires you to have a referral from your PCP, it is your responsibility to ensure that the referral information and referral number is received by this office from your PCP prior to your visit.

We accept all major credit cards, FSA/HSA cards, Apple Pay, Google Pay, electronic check, cash, personal checks. Payment of all estimated out-of-pocket expenses (co-pays, deductible, co-insurance, etc.) is required at the time of your visit. Please come prepared to make payment of these amounts. Your insurance policy is a contract between you and your insurance carrier. The ultimate responsibility for payment of services rendered rests with you the patient or guarantor.

If we are not in your insurance network or if you have no insurance, we will expect payment in full at the time of service. Please call our office for our current fee schedule.

Lomibao Rheumatology & Wellness Care, PLLC is not a Medicaid participating provider and does not accept Worker’s Compensation or Disability cases.

We have implemented a policy requiring a card to be held on file for all patients. Lomibao Rheumatology & Wellness Care, PLLC securely stores credit and debit cards on file with InstaMed to streamline processes working with patients, such as if there is a need to charge for a co-pay, cancellation or no show fee. Your card is NOT charged when it is added to the platform. The billing department will communicate all charges directly to you prior to charging your card.

InstaMed is healthcare’s most trusted payments network, and unmatched when it comes to security and compliance. InstaMed is a Payment Card Industry Data Security Standard (PCI DSS) Level One v3.2 Service Provider, as well as EMV and HITRUST certified. InstaMed was the first in healthcare to be PCI-validated for P2PE v2.0, which is a methodology for securing credit card data by encrypting it from the time a card is swiped or keyed until it reaches a secure endpoint (InstaMed) where it is decrypted.

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to the Financial Policy, Billing Procedures, Card on File Policy of Lomibao Rheumatology & Wellness Care, PLLC.

_____ _____

Patient Signature **Date**

7700 Lakeview Pkwy Suite 300A
Rowlett, TX 75088
Phone: 469-825-4010
Fax: 469-825-4020

Last_____ First_____ DOB_____/_____/_____

Consent to Receive Medical Care

I hereby authorize Lomibao Rheumatology & Wellness Care, PLLC and any employee working under direction of the physician to provide medical care for me. This medical care may include services and supplies related to my health and may include but not limited to preventive, diagnostic, therapeutic, rehabilitative, maintenance, counseling, assessment or review of physical or mental status/function of the body. This consent includes contact and discussion with other health care professionals for care and treatment.

_____ _____

Patient Signature **Date**

Consent for Telemedicine

1. I hereby authorize Lomibao Rheumatology & Wellness Care, PLLC to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition(s).

2. I understand that it is my responsibility to set up and learn how to use the telehealth system *prior* to my scheduled appointment time.

3. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

4. I accept that the professionals intend to offer the telehealth sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

5. I understand that my current insurance may not cover the fees for telehealth practices and I may be responsible for any fee that my insurance company does not cover for this service.

_____ _____

Patient Signature **Date**

☐ check here if declines telemedicine

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Patient Preference Regarding Communication of Personal Health Information

I hereby grant permission for Lomibao Rheumatology & Wellness Care, PLLC to disclose and discuss any information related to my medical condition(s) with the following individual(s), if requested by said individual(s):

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

☐ I do not wish to grant permission for any individual(s) to have access to any information regarding my medical condition(s).

Last_____ First_____ DOB_____/_____/_____

COVID-19 Risk Patient Informed Consent and Acknowledgment

The novel coronavirus (COVID-19) has been declared a worldwide pandemic by the World Health Organization. Lomibao Rheumatology & Wellness Care, PLLC is taking measures to comply with federal, state, and Centers for Disease Control (CDC) infection control guidelines to prevent the spread of the COVID-19 virus, but we cannot make any guarantees about your health and safety. Therefore, to proceed with your Lomibao Rheumatology & Wellness Care, PLLC treatment, please read the below and indicate your agreement by signing.

Informed Consent
I understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing.

I recognize that: (i) Lomibao Rheumatology & Wellness Care, PLLC has implemented reasonable preventative measures aimed to help reduce the spread of COVID-19; (ii) to Lomibao Rheumatology & Wellness Care, PLLC's knowledge, its providers and employees at this location have acknowledged that they don't have symptoms of COVID-19; and (iii) because Lomibao Rheumatology & Wellness Care, PLLC provides healthcare services, other persons (including other patients) could be infected, with or without Lomibao Rheumatology & Wellness Care, PLLC's knowledge, that may have been on Lomibao Rheumatology & Wellness Care, PLLC's premises.

Therefore, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with my treatment. I understand that possible exposure to COVID-19 during my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, intensive care treatment, short-term or long-term intubation, other potential complications, and the risk of death. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein. I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19.

By signing below, I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment visit, and I give express consent for my Lomibao Rheumatology & Wellness Care, PLLC provider and staff at this location to proceed with treating me.

I represent that I have been practicing all current CDC guidelines with respect to "social distancing," and, to my knowledge, I neither have symptoms of COVID-19, have COVID-19, nor have I been in contact with a person who has tested positive for, or who is suspected to be positive for, COVID-19.

By signing below, I hereby acknowledge and represent that I have: (i) been informed by Lomibao Rheumatology & Wellness Care, PLLC of its desire to protect its patients, staff, and the community at large; and (ii) been given the option to defer my treatment to a later date.

_____ _____

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Last_____ First_____ DOB_____/_____/_____

Medication Refill & Controlled Substance/Psychoactive Drugs Policy

In order to provide the best care possible, please always come prepared to your appointment with your list of medications you need refilled. Otherwise, please contact your pharmacy regarding refills. Lomibao Rheumatology & Wellness Care, PLLC does not send routine refills when the office is closed such as after hours, weekends, or holidays. It is your responsibility to come prepared to your appointment with your refill list.

Lomibao Rheumatology & Wellness Care, PLLC is strictly a no-narcotic, no-psychoactive drugs, and no-controlled substance practice, this includes but is not limited to:

1. DEA Schedule II Narcotics such as: hydromorphone (Dilaudid), methadone (Dolophine), meperidine (Demerol), oxycodone (OxyContin, Percocet), and fentanyl (Sublimaze, Duragesic), morphine, opium, codeine, and hydrocodone, (Tylenol with Codeine), (Robitussin AC, Phenergan with Codeine) and buprenorphine (Suboxone).
2. DEA Schedule II Stimulants such as: amphetamine (Dexedrine, Adderall), methamphetamine (Desoxyn), and methylphenidate (Ritalin).
3. DEA Schedule III others such as: benzphetamine (Didrex), phendimetrazine, ketamine, and anabolic steroids such as Depo-Testosterone.
4. DEA Schedule IV Depressants such as: tramadol (Ultram), alprazolam (Xanax), carisoprodol (Soma), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), lorazepam (Ativan), midazolam (Versed), temazepam (Restoril), and triazolam (Halcion).
5. DEA Schedule V anti-seizure drugs such as: gabapentin (Neurontin), pregabalin (Lyrica).
6. Psychoactive drugs Antidepressants and Antianxiolytics such as: Fluoxetine (Prozac), Paroxetine (Paxil, Seroxat), Citalopram (Celexa), Escitalopram (Lexapro), Sertraline (Zoloft), Duloxetine (Cymbalta), Milnacipran (Savella), Venlafaxine (Effexor), Bupropion (Wellbutrin), Mirtazapine (Remeron), Isocarboxazid (Marplan), Phenelzine (Nardil), Tranylcypromine (Parnate), Amitriptyline (Elavil).

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to the Medication Refill & Controlled Substance/Psychoactive Drugs Policy of Lomibao Rheumatology & Wellness Care, PLLC.

_____ _____

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Appointment Confirmation Policies

Appointment Confirmation:
We will call to remind you of your scheduled appointment 2 business days prior. It is imperative to confirm that you are coming to your appointment, or your appointment time may be offered to another patient. (method of confirmation subject to change when Patient Portal becomes available)

New Patient Preparation:
Please review how to prepare for your first appointment in the FAQ section of our website lomibaorheumatology.com.

Arrival to Clinic:
We request that new patients arrive 20 minutes prior to appointment time and established patients arrive 10 minutes prior to appointment time, to allow for any unforeseen issues such as insurance verification, address change, etc. to be addressed at check-in. This will also enable you to have enough time to be triaged by the Medical Assistant (MA) to then start your visit with the doctor at the start of your appointment time.

Late Arrivals:
In order to provide the best care possible for all patients, we strive to run the clinic in a timely fashion and respect your time, and we ask that you do the same. We reserve the right to reschedule an appointment if a patient arrives 10 or more minutes late for a new patient appointment, or 5 or more minutes late for a follow-up appointment. We strive to be fair to those who show up early and on time.

Cancellations/Rescheduling & No Show's:
If you are unable to come for your appointment for any reason, we must have **24 hours or 1 full business weekday** in advance of the cancellation/rescheduling. (Note that we are closed Thanksgiving Day, Christmas Day, New Years Day, Memorial Day, Independence Day, Labor Day, so these do not count as a business day.) For example, you must provide notice on a Friday at 9AM to cancel for a Monday 9AM appointment. This is the fairest way to allow another patient the chance to be offered your appointment time.

Failure to provide this advance notice will incur a **$50 cancellation fee**. Those who do not show for their appointment will incur a **$50 no show fee** as this is time lost that another patient could have used. Cancellation fees are not reimbursable through insurance so this fee would be your responsibility.

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the Appointment Confirmation Policies of Lomibao Rheumatology & Wellness Care, PLLC.

_____ _____

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Forms & Medical Records Copies Policies

If clinically warranted and agreeable, the physicians at Lomibao Rheumatology & Wellness Care, PLLC will review and sign FMLA and Parking Placard forms. The fee for each time FMLA forms are filled out is $40 and the fee for each time Parking Placard forms are filled out is $20. These fees are not reimbursable by insurance and paid upon request of forms to be filled out. It is the patient's responsibility to bring a paper copy of the forms they want filled out each time.

Lomibao Rheumatology & Wellness Care, PLLC does not fill out Disability forms of any kind or get involved in the legal intricacies of Disability of any kind. If you need your medical records to support a Disability claim that is being handled by another provider, or for any reason, we will provide you with copies upon request.

The fee for providing patients with paper copies of medical records is $25 for the first twenty pages and $0.50 per page for every copy thereafter. The fee for providing patients with copies of medical records in electronic format is $25 for 500 pages or less and $50 for more than 500 pages.

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the Forms & Medical Records Copies Policies of Lomibao Rheumatology & Wellness Care, PLLC.

_____ _____

Patient Signature **Date**

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Clinical History Intake

How did you hear about us?

What is your Reason for Referral?

What is the History of your Present Illness? (ie. onset, location, duration, characteristics, aggravating or alleviating factors, treatments attempted)

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Last_____ First_____ DOB_____/_____/_____

Medications - please list both prescription & over-the-counter ☐ check here if not taking any medications

Name	Dose	Frequency	When started taking

Allergies - tell us what type of reaction happens Others:

☐ check here if no known drug allergies

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Insulin
- ☐ Penicillin
- ☐ Sulfa

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Last_____ First_____ DOB_____/_____/_____

Review of Systems - Please circle if you are ***currently*** experiencing any of the following.
If you are not experiencing any of these, please circle None in each category.

Constitutional	Cardiovascular	Metabolic/endocrine	Skin
None	None	None	None
Chills	Chest pain	Cold intolerance	Discoid rash
Fatigue	Palpitations	Hair loss	Nail changes
Night sweats	Raynaud's	Heat intolerance	Extreme sun sensitivity
Weight gain			Psoriasis
Weight loss	Gastrointestinal	Neurological	
	None	None	Musculoskeletal
HEENT	Abdominal pain	Confusion	None
None	Bloody stools	Extremity numbness	Height loss
Vision loss	Constipation	Headache	Joint pain
Blurred vision	Diarrhea	Memory loss	Joint swelling
Dental decay	Difficulty swallowing	Seizures	Joint tenderness
Dry mouth	Heartburn	Fainting	Low back pain
Dry eyes	Nausea	Stroke	Morning stiffness
Nose bleeds	Vomiting		Muscle cramping
Hearing loss		Psychiatric	Muscle weakness
Nasal sores	Genitourinary	None	Neck pain
Oral ulcers	None	Anxiety	
Red eye	Painful urination	Depression	Hematologic/lymph
Sinusitis	Bloody urine	Emotionally labile	None
	Urinary frequency	Hallucinations	Easy bleeding
Respiratory		Insomnia	Easy bruising
None			Blood clots
Cough		Immunologic	
Bloody cough		None	
Pleurisy		Allergic rhinitis	
Shortness of breath		Frequent infections	
		Food allergies	

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Last_____ First_____ DOB_____/_____/_____

Past Medical History

Others:

☐ check here if no past medical history

Please select any of the illnesses you have had in the past.

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Depression
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ GERD
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Kidney stones

Past Surgical History

Others:

☐ check here if no surgical history

Please select any of the surgeries or procedures you have ever had.

- ☐ Cataract
- ☐ Appendectomy
- ☐ Breast Biopsy
- ☐ Cataracts
- ☐ Gall bladder
- ☐ Heart bypass
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Hip surgery
- ☐ Hysterectomy
- ☐ Knee surgery
- ☐ Tonsillectomy
- ☐ Tubes tied
- ☐ Vasectomy

Last_____ First_____ DOB_____/_____/_____

Family Health History

If alive and well please specify age; if deceased please specify age and cause of death.

M - mother
F - father
M GM - maternal grandmother
M GF - maternal grandfather
P GM - paternal grandmother
P GF - paternal grandfather
Son - son
Dau - daughter
Bro - brother
Sis - sister
C - cousin
M A - maternal aunt
P A - paternal aunt
M U - maternal uncle
P U - paternal uncle

Please specify the relationship of the individual with the affected condition(s) using the letter codes above:

ADD/ADHD
Alcoholism
Allergies
Alzheimer's disease
Arthritis - specify what type
Asthma
Blood disorder
Cancer - specify what type
Cardiovascular disease
Coronary artery disease
Depression
Developmental Delay
Diabetes Type 1
Diabetes Type 2
Elevated lipids
Genetic disease
Hearing deficiency
Hypertension
Irritable bowel syndrome
Learning disability
Mental illness
Migraines
Obesity
Osteoporosis
Peripheral vascular disease
Renal disease
Seizure disorder
Stroke
Systemic lupus
Thyroid disorder
Others:

Social History

What is your tobacco and alcohol history?

Uses tobacco: ○ Current ○ Never ○ Former ○ Unknown

Type: ▼

Number of years: ☐

Packs per day: ☐

Tobacco per day: ▼

Ever tried to quit: ○ Yes ○ No

Year quit: ☐

Passive Smoke Exposure:

○ Yes ○ No

Drinks Alcohol: ○ Yes ○ No ○ Formerly

Type: ▼

Frequency: ▼

Amount: ▼

Last drink: ▼

Year quit: ☐

Caffeine: Yes No Type:

Amount: Frequency:

Education: High school College Graduate school Doctorate

Status: Full-time Part-time Retired

Occupation:

7700 Lakeview Pkwy Suite 300A
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Sleep Patterns:

Changes in sleep patterns: ○ No ○ Yes Details

Lifestyle:

Activity level: ❖ Cultural Practices

Health club member: ○ Now ○ Previously ○ Never

Type of exercise:

Exercise frequency: Hours/week:

Hobbies/activities: Hours/week:

Diet history:

Animals in the home: ○ No ○ Yes

Average number of hours of sleep per night:

Trouble falling asleep: ○ No ○ Yes

Difficulty staying asleep: ○ No ○ Yes

Frequent waking episodes at night: ○ No ○ Yes

Disrupted breathing, gasping, gagging or choking for air during sleep: ○ No ○ Yes

Religious/Spiritual:

Do you have a religious affiliation? ○ No ○ Yes

Do you practice your religion? ○ No ○ Yes

Do you have spiritual beliefs? ○ No ○ Yes

Is religion/spirituality an important part of your life? ○ No ○ Yes

Agrees to blood/blood products? ○ No ○ Yes

Home Environment/Safety:

No Yes *All "Falls" questions must be answered for MU Credit.*

○ ○ Falls in the last year? Number/falls: ❖ Fall Risk Plan

○ ○ Did the fall(s) result in injury?

Details:

○ ○ Is the patient at risk for falls? ❖ Exclusions

○ ○ Firearms in home

○ ○ Seatbelt use in vehicle

No Yes

○ ○ Smoke detectors in home

○ ○ Carbon monoxide detectors in home

○ ○ Radon in home: ○ Treated ○ Untested

Home heating:

○ ○ Pool/spa at home

Recent Travel:

☐ Out of state

☐ Out of country

☐ Travel exposure

Last_____ First_____ DOB_____/_____/_____

Multi-Dimensional Health Assessment Questionnaire (MDHAQ)

Office Use Only:

FN (0-10) ____
PN (0-10) ____
PTGL (0-10) ____
RAPID 3 (0-30) ____
PTJT (0-10) ____
RAPID 4 (0-40) ____
RAPID 3 (0-10) ____
RAPID 4 (0-10) ____

Please select the ONE best answer for your abilities at this time.

OVER THE LAST WEEK, were you able to:	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
Dress yourself including tying shoelaces and doing buttons?	0	1	2	3
Get in and out of bed?	0	1	2	3
Lift a full cup or glass to your mouth?	0	1	2	3
Walk outdoors on flat ground?	0	1	2	3
Wash and dry your entire body?	0	1	2	3
Bend down to pick up clothing from the floor?	0	1	2	3
Turn faucets on and off?	0	1	2	3
Get in and out of a car, bus, or airplane?	0	1	2	3
Walk two miles if you wish?	0	1	2	3
Participate in recreational activites and sports as you would like, if you wish?	0	1	2	3
Get a good night's sleep?	0	1	2	3
Deal with feelings of anxiety or being nervous?	0	1	2	3
Deal with feelings of depression or feeling blue?	0	1	2	3

How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate how severe your pain has been:

NO PAIN 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 PAIN AS BAD AS IT COULD BE

Please check in the appropriate spot to indicate the amount of pain you are having TODAY in each of the joint areas listed below:

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
LEFT FINGERS	0	1	2	3	RIGHT FINGERS	0	1	2	3
LEFT WRIST	0	1	2	3	RIGHT WRIST	0	1	2	3
LEFT ELBOW	0	1	2	3	RIGHT ELBOW	0	1	2	3
LEFT SHOULDER	0	1	2	3	RIGHT SHOULDER	0	1	2	3
LEFT HIP	0	1	2	3	RIGHT HIP	0	1	2	3
LEFT KNEE	0	1	2	3	RIGHT KNEE	0	1	2	3
LEFT ANKLE	0	1	2	3	RIGHT ANKLE	0	1	2	3
LEFT TOES	0	1	2	3	RIGHT TOES	0	1	2	3
NECK	0	1	2	3	BACK	0	1	2	3

Considering all the ways in which illness and health conditions may affect you at this time, please indicate how you are doing:

VERY WELL 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 VERY POORLY

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Last_____ First_____ DOB_____/_____/_____

Multi-Dimensional Health Assessment Questionaire (MDHAQ) - Page 2

Please check below if you have experienced any of the following over the last month ☐ None

- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Feeling Sickly
- ☐ Headaches
- ☐ Unusual Fatigue
- ☐ Swollen Glands
- ☐ Loss of Appetite
- ☐ Skin Rash
- ☐ Hives
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Other Skin Problems: _____
- ☐ Loss of Hair
- ☐ Dry Eyes
- ☐ Other Eye Problems: _____
- ☐ Problems with Hearing
- ☐ Ringing in the Ears
- ☐ Stuffy Nose
- ☐ Sores in the mouth
- ☐ Dry Mouth
- ☐ Problems with Smell or Taste
- ☐ Lump in Throat
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Pain in Chest
- ☐ Heart Pounding
- ☐ Trouble Swallowing
- ☐ Heartburn
- ☐ Stomach Pain or Cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dark or Bloody Stools
- ☐ Problems with Urination
- ☐ Gynecologic (female) Problems
- ☐ Dizziness
- ☐ Losing your Balance
- ☐ Muscle Pain, Aches, or Cramps
- ☐ Muscle Weakness
- ☐ Paralysis of Arms or Legs
- ☐ Numbness or Tingling of Arms or Legs
- ☐ Fainting Spells (syncope)
- ☐ Swelling of Hands
- ☐ Swelling of Ankles
- ☐ Swelling in Other Joints
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Use of Drugs not Sold in Stores
- ☐ Smoking Cigarettes
- ☐ More Than 2 Alcoholic Drinks a D
- ☐ Depression
- ☐ Anxiety
- ☐ Problems with Thinking
- ☐ Problems with Memory
- ☐ Problems with Sleeping
- ☐ Sexual Problems
- ☐ Burning in Sex Organs
- ☐ Problems with Social Activities

When you awakened in the morning OVER THE LAST WEEK, did you feel stiff?

○ No ○ Yes Stiffness lasted: _____

How do you feel TODAY compared to ONE WEEK AGO? (Please check only one.)

○ Much Better (1) ○ Better (2) ○ the same (3) ○ Worse (4) ○ Much worse than a week ago. (5)

How often do you excercise aerobically (sweating, increased heart rate, shortness of breath) for at least 30 minutes?

○ 3 or more times a week (3) ○ 1-2 times per week (2) ○ Cannot exercise due to disability/handicap
○ 1-2 times per month (1) ○ Do not exercise regularly (0)

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

Fatigue is NO PROBLEM. ○ 0 ○ 0.5 ○ 1.0 ○ 1.5 ○ 2.0 ○ 2.5 ○ 3.0 ○ 3.5 ○ 4.0 ○ 4.5 ○ 5.0 ○ 5.5 ○ 6.0 ○ 6.5 ○ 7.0 ○ 7.5 ○ 8.0 ○ 8.5 ○ 9.0 ○ 9.5 ○ 10 Fatigue is a MAJOR PROBLEM.

Over the last six months, have you had: (Please Check)

NO	YES		NO	YES	
○	○	An operation or new illness	○	○	Changes(s) of arthritis or other medication
○	○	Medical emergency or overnight stay in a hospital	○	○	Change(s) of address
○	○	A fall, broken bone or other accident or trauma	○	○	Change(s) of marital status
○	○	An important new symptom or medical problem	○	○	Change job or work duties, quit work, retired
○	○	Side effect(s) of any medication or drug	○	○	Change of medical insurance, Medicare etc
○	○	Smoke cigarettes regularly	○	○	Change of primary care or other doctor

Please explain any " Yes" answer below, or indicate any other health matter that affects you:

_____

Please tell us what YOU suspect is the cause of your current issue?

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