

**ALL FAMILY CARE, PC**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_  
MAILING ADDRESS \_\_\_\_\_ APT \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ SS# \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
ETHNICITY: HISPANIC \_\_\_\_\_ NON-HISPANIC \_\_\_\_\_ (REQUIRED BY FEDERAL GOVERNMENT)  
RACE: \_\_\_\_\_ I DECLINE TO LIST MY RACE: \_\_\_\_\_ (REQUIRED BY GOVERNMENT)  
PRIMARY LANGUAGE SPOKEN: ENGLISH: \_\_\_\_\_ OTHER: \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ STUDENT \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

WHOM MAY WE THANK FOR THE REFERRAL? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

\*\*\*WHO'S RESPONSIBLE FOR THIS VISIT? YOURSELF\_\_ PARENT\_\_ (PLEASE CIRCLE APPLICABLE ONE)

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**INSURED'S INFORMATION PLEASE GIVE CARDS TO OFFICE STAFF PRIOR TO VISIT!!!**

NAME OF POLICY HOLDER \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
PRIMARY INSURANCE \_\_\_\_\_ HMO\_\_ PPO\_\_ ICA\_\_ SELFPAY\_\_ EMPLOYER \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ INSURANCE COMPANY PHONE \_\_\_\_\_  
INSURANCE ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
DO YOU HAVE COPAY? YES\_\_ NO\_\_ (PLEASE CIRCLE ONE) AMOUNT \_\_\_\_\_ EFFECTIVE DATES \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ INSURANCE COMPANY PHONE \_\_\_\_\_  
INSURANCE ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

IF THIS IS AUTO/INDUSTRIAL INJURY, PLEASE PROVIDE THE FOLLOWING: DATE OF INJURY \_\_\_\_\_  
CLAIM # \_\_\_\_\_ CLAIMS ADJUSTOR \_\_\_\_\_ PHONE # \_\_\_\_\_

Authorization to pay insurance benefits to physician: I hereby authorize payment directly to All Family Care, PC. Authorization to release information: I hereby authorize All Family Care, PC to release all medical information needed to process this claim. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for services rendered to the patient in the event that my insurance coverage does not pay. In the event of default, I promise to pay any collection costs and reasonable attorney fees, as may be required to collect for my services.

SIGNATURE OF PATIENT OF PATIENT OR PARENT IF MINOR \_\_\_\_\_ DATE \_\_\_\_\_

**ALL FAMILY CARE, PC.**

GARDEN LAKES PLAZA  
4120 N. 108<sup>TH</sup> AVE. STE. #116  
PHOENIX, AZ 85037  
PHONE: 623-872-1818  
FAX: 623-872-1819

CANYON TRAILS PROF. CENTER  
700 N. ESTRELLA PKWY. STE: 120  
GOODYEAR, AZ 85338  
PHONE: 623-925-0636  
FAX: 623-925-0637

**Acknowledgement of Receipt of Privacy Notice**

I acknowledge that I have read or been offered a copy of the office's Notice of Privacy Practices.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative, etc.)

**PATIENT PORTAL/EMAIL/TEXT AUTHORIZATION**

You will be able to obtain you/your child's medical information securely online through our new Patient Portal free of charge. This information may include office notes, medical history, immunization history, prescription history, lab and radiology records. You will also be able to request WELL CHECKS AND REFERRALS. You may also receive phone messages/emails/text regarding upcoming appointments, billing statements, and reminders for yearly WELL CHECKS, mammograms, colonoscopies, seasonal shots such as FLU SHOTS.

In order for us to link the account to our system we will be need an email address. We can only have one email address per patient/legal guardian. If you wish to participate. Please complete the following:

Patient/legal Guardian Name: \_\_\_\_\_

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

EMAIL: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

**\*\*\*PLEASE PRINT CLEARLY\*\*\***

**ADVANCED DIRECTIVES**

The state of Arizona regulations require that your medical chart contain the following information. You will be asked if you have a living will, have assigned a Medical Power of Attorney or designated a Surrogate to act on your behalf.

**Please complete the following and acknowledge your response by signing below.**

\_\_\_\_\_ I have a Living Will. State location if possible \_\_\_\_\_

\_\_\_\_\_ I have a Medical Power of Attorney. Designee if available \_\_\_\_\_

\_\_\_\_\_ I have Designated a Surrogate. Name of Surrogate \_\_\_\_\_

\_\_\_\_\_ I have none of the above and do not wish one

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

\_\_\_\_\_  
Date

**ALL FAMILY CARE, PC.**

GARDEN LAKES PLAZA  
4120 N. 108<sup>TH</sup> AVE. STE. #116  
PHOENIX, AZ 85037  
PHONE: 623-872-1818  
FAX: 623-872-1819

CANYON TRAILS PROF. CENTER  
700 N. ESTRELLA PKWY. STE: 120  
GOODYEAR, AZ 85338  
PHONE: 623-925-0636  
FAX: 623-925-0637

**AUTHORIZATION FOR RELEASE OF INFORMATION**

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

This authorization allows the following physician/facility to release my medical records including but not limited to progress notes, consultations, test results including imaging and lab work, immunizations, phycological/psychiatric records, HIV and communicable diseases to the Dr. Singh at ALL FAMILY CARE, PC.

PHYSICIAN/FACILITY

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

SIGNATURE OF PATIENT

/GURADIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO SHARE MEDICAL INFORMATION (OPTIONAL)**

I do hereby authorize ALL FAMILY CARE, PC to allow the following individuals to have access and discuss with Dr. Singh my personal medical records, medical history and all pertaining information. I understand that this also includes psychiatric/psychological treatment, HIV and communicable related diseases. In accordance with federal regulation 42CFR Part 2, I hereby consent to the release of records pertaining to drug and alcohol abuse.

I understand that I may revoke this consent at any time in writing to the office of All Family Care, PC. This consent will automatically renew every 12 months without my written revocation.

\_\_\_\_\_  
Authorized Person (s) Relationship to patient

\_\_\_\_\_  
Date

# ALL FAMILY CARE, P.C.

## FINANCIAL POLICY

Welcome to All Family Care  
(Effective September 21 2017)

YOU WILL BE REQUIRED TO SIGN A NEW FINANCIAL AGREEMENT EVERY 12 MONTHS.

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Thank you for choosing All Family Care, P.C. We are committed to providing the finest personalized family care. Please carefully read and sign the following statement of our office policies prior to your treatment. Feel free to speak to our practice manager or billing department if you have any questions.

### **INSURANCE:**

You are ultimately responsible for payment of services if your insurance carrier does not pay for any reason. **IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE.** Please present your insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. Current policies in the "ACA" Affordable Care Act may delay payment of your claims due to non-payment of policy premiums by the patient. If your insurance delays, denies or pays and then re-coups the payment of your claims due to non-payment of the policy premium, you will be responsible to pay the claim in full in accordance with our "Financial Policy" guidelines.

The patient is responsible for obtaining all necessary information regarding referrals or authorizations to another physician. Failure to do so may result in denial or delay of payments. Please allow five days for the office to obtain your referral.

### **NO SHOW/LATE CANCELLATION FEE:**

If you need to cancel your appointment, please contact our office **at least 24 hours before** your appointment time. Because of the high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. A \$50.00 fee will be assessed for all missed appointments not canceled with **at least 24 hour** advance notice.

### **BILLING:**

As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification and your insurance card. Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.

In order to keep billing costs to a minimum, all co-pays, co-insurance and deductibles are to be paid on the day of the visit without exception. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in. For your convenience, we accept credit and debit cards from Master Card, Visa, cash and check.

# ALL FAMILY CARE, PC.

## FINANCIAL POLICY

Welcome to All Family Care  
(Effective September, 21 2017)

PAGE 2

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an "out of network provider" for your insurance, the deductibles and co-insurance amounts may be higher. Your insurance policy, not our office, determines the amounts. After your insurance company processes your claims, you will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you. Patient balances are due and payable in full upon receipt of your statement. Accounts which remain unpaid after 30 days will be assessed a late fee of \$5.00 per month. Delinquent accounts will be transferred to a collection agency or our attorney after 90 days.

In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for as long as the law provides.

Please understand maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect.

There will be a \$30.00 service fee for all returned checks. Any checks returned for any reason must be paid with certified funds (cashier check, money order or cash).

### **PRESCRIPTION REFILLS:**

Please plan ahead for prescription refills. We encourage you to address refills at the time of your office visit. Any changes in medication, new prescription, or mail in prescription problems require an office visit. No prescription refills will be granted on weekends, after hours or during routine well visits.

We respect your time and every attempt is made to run on schedule. Therefore, we ask you to arrive on time for your appointment. If you are late, you may be asked to reschedule. If your doctor is running behind due to emergencies and you need to reschedule, please notify the office staff. If you choose to stay, your visit will be given the same consideration.

I have read and understand the above policy and I agree to abide by the terms stated within.

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Signature of patient/responsible party

\_\_\_\_\_  
Date

# ALL FAMILY CARE, PC.

## YEARLY UPDATE PACKET

\*\*\*\*PLEASE PRINT CLEARLY\*\*\*\*

### PATIENT PORTAL/EMAIL/TEXT AUTHORIZATION

You will be able to obtain you/your child's medical information securely online through our new Patient Portal free of charge. This information may include office notes, medical history, immunization history, prescription history, lab and radiology records. You will also be able to request WELL CHECKS AND REFERRALS. You may also receive emails/text regarding upcoming appointments, billing statements, and reminders for yearly WELL CHECKS, mammograms, colonoscopies, seasonal shots such as FLU SHOTS.

In order for us to link the account to our system we will be need an email address. We can only have one email address per patient/legal guardian. If you wish to participate. Please complete the following

Patient/legal Guardian

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

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

EMAIL: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

### ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: YOU NEED TO MAKE A CHOICE ABOUT RECEIVING THESE SERVICES

We expect that YOUR INSURANCE may not pay for the services described below. YOUR INSURANCE does not pay for all of your health care costs. YOUR INSURANCE only pays for what they determine to be covered items and services. The fact that YOUR INSURANCE may not pay for a particular item or service does not mean that you should not receive it; there is a reason your doctor recommended it. The following list includes, but is not limited to, services that may not be covered by YOUR INSURANCE:

BLOOD DRAWS, LABS, VACCINATIONS, INJECTIONS, SPECIAL PROCEDURES OR ANY OTHER SPECIFIC ITEM OR SERVICES YOUR INSURANCE POLICY DEEMS NOT COVERED.

The purpose of this letter is to help you make an informed choice about whether or not you want to receive services from ALL FAMILY CARE, PC knowing that you might have to pay for them yourself. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s) if your health insurance does not include this as a covered item or service.

\_\_\_\_\_  
Signature of Patient or person acting on Patient's behalf

\_\_\_\_\_  
Date

# ALL FAMILY CARE, PC.

GARDEN LAKES PLAZA  
4120 N 108<sup>TH</sup> AVE. STE: 116  
PHOENIX, AZ. 85037  
PHONE: 623-872-1818  
FAX: 623-872-1819

CANYON TRAILS PROF. CENTER  
700 N ESTRELLA PKWY. STE: 120  
GOODYEAR, AZ. 85338  
PHONE: 623-925-0636  
FAX: 623-925-0637

TODAY'S DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ S.S.# \_\_\_\_\_

DO YOU HAVE A LIVING WILL?       Yes       No

ANY ADVANCE DIRECTIVES       Yes       No

PHARMACY Name : \_\_\_\_\_

Phone #: \_\_\_\_\_

MAIN REASON OF VISIT / CHIEF COMPLAINT:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

MEDICATIONS:

<u>Name</u>	<u>Dose and Frequency</u>	<u>Name</u>	<u>Dose and Frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:       No Medication Allergy

<u>Name</u>	<u>Adverse Reaction</u>	<u>Name</u>	<u>Adverse Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# ALL FAMILY CARE, PC.

## MEDICAL HISTORY. (Please Check All Applicable)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Migraine Headache  | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Stroke             | <input type="checkbox"/> COPD                   |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Mini Stroke / TIA  | <input type="checkbox"/> Emphysema              |
| <input type="checkbox"/> Palpitations            | <input type="checkbox"/> Seizure            | <input type="checkbox"/> Chronic Bronchitis     |
| <input type="checkbox"/> Atrial Fibrillation     | <input type="checkbox"/> Parkinson's        | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> CHF                     | <input type="checkbox"/> Dementia           | <input type="checkbox"/> Pneumonia              |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Depression         | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> Hyperlipidemia          | <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Heart Burn / GERD      |
| <input type="checkbox"/> Recurrent UTI           | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Gastric Ulcers         |
| <input type="checkbox"/> Chronic Anemia          | <input type="checkbox"/> Sinusitis          | <input type="checkbox"/> Duodenal Ulcers        |
| <input type="checkbox"/> Gout                    | <input type="checkbox"/> Kidney Problem     | <input type="checkbox"/> Pancreatitis           |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Diverticulitis         |
| <input type="checkbox"/> Diabetes Mellitus       | <input type="checkbox"/> Lupus              | <input type="checkbox"/> Fibromyalgia           |
| <input type="checkbox"/> Thyroid problem         | <input type="checkbox"/> Bleeding Problem   | <input type="checkbox"/> Prostate Problem / BPH |
| <input type="checkbox"/> DVT/ PE                 | <input type="checkbox"/> Aneurysm           | <input type="checkbox"/> STD / HIV / AIDS       |
- Cancer. If yes. Where \_\_\_\_\_ Any Metastasis: \_\_\_\_\_
- Any other Medical Cond.: \_\_\_\_\_

## SURGICAL HISTORY (Please Check All Applicable)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cataract   | <input type="checkbox"/> Tonsillectomy  | <input type="checkbox"/> Adenoidectomy  |
| <input type="checkbox"/> Ears   | <input type="checkbox"/> Nose   | <input type="checkbox"/> Throat         |
| <input type="checkbox"/> Thyroid  | <input type="checkbox"/> Heart Bypass / CABG  | <input type="checkbox"/> Carotid        |
| <input type="checkbox"/> Angioplasty  | <input type="checkbox"/> Angioplasty with Stent   | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Appendectomy   | <input type="checkbox"/> Gastric Bypass   | <input type="checkbox"/> Colon          |
| <input type="checkbox"/> Prostate. Complete / TURP  | <input type="checkbox"/> Hernia repair _____  | <input type="checkbox"/> Hemorrhoids    |
| <input type="checkbox"/> Gall Bladder (Cholecystectomy)   | <input type="checkbox"/> Uterus (Hysterectomy) <input type="checkbox"/> Complete <input type="checkbox"/> Partial |   |
| Breast Surgery <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Augmentation <input type="checkbox"/> Reduction |   |   |
| <input type="checkbox"/> Hip replacement R / L <input type="checkbox"/> Knee replacement R / L <input type="checkbox"/> Spine                                   |   |   |
| <input type="checkbox"/> Plastic Surgery _____ <input type="checkbox"/> Tumor / Cancer _____  |   |   |
| <input type="checkbox"/> Any other Surgery _____  |   |   |
| Colonoscopy _____ Upper Endoscopy _____   |   |   |

## IMMUNIZATION HISTORY

- Tetanus: \_\_\_\_\_ Hepatitis \_\_\_\_\_
- FLU Shot: \_\_\_\_\_ Other: \_\_\_\_\_
- Pneumonia \_\_\_\_\_



# ALL FAMILY CARE, PC.

## PERSONAL HISTORY : (Please Check All Applicable)

MARITAL STATUS       S                       M                       D                       Sep                       W

SMOKING       NO       YES      How Much? \_\_\_\_\_ PPD.      Since (Year) \_\_\_\_\_

ALCOHOL       NO       YES      How Much? \_\_\_\_\_      Since (Year) \_\_\_\_\_

ILLICIT DRUGS     NO                       YES      Name of Drug \_\_\_\_\_

Where do you Live:     Own Home/Condo                       ALF     ILF                       NH

Who do you live with:     Alone                       With: spouse / son / daughter/Other

Children                       None                      Son: \_\_\_\_\_                      Daughter: \_\_\_\_\_

Profession:                       Retired                       Working as: \_\_\_\_\_

## FAMILY HISTORY:

	<u>AGE</u>	<u>ALIVE</u>	<u>DECEASED</u>	<u>AGE OF DEATH</u>	<u>CAUSE OF DEATH</u>
FATHER	_____	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____	_____
SISTER	_____	_____	_____	_____	_____
SON	_____	_____	_____	_____	_____
DAUGHTER	_____	_____	_____	_____	_____

**Do any of following conditions runs in your family.** (Parents, Grand-Parents, Siblings, Children etc.)

- Hypertension:  Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Heart Attack:  Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Dementia :     Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Anxiety                       Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Suicide:                       Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Diabetes:                       Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Stroke:                       Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Cancer :                       Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Asthma:                       Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother
- Depression:  Mother     Father     Brother     Sister     Son     Daughter     Grand father     Grand mother

# ALL FAMILY CARE, PC.

## REVIEW OF SYSTEM:

<u>General</u>	<u>YES</u>	<u>NO</u>	<u>GASTROINTESTINAL</u>	<u>YES</u>	<u>NO</u>
Recent Fever	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Undue Tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Easy Fatigability	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
<u>Head / CNS</u>			Chronic Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Heart Burn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Black Stool	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITO-URINARY</u>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Pain or Burning on Urination	<input type="checkbox"/>	<input type="checkbox"/>
<u>Eye &amp; ENT</u>			Increased Frequency	<input type="checkbox"/>	<input type="checkbox"/>
Blurring of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	Trouble starting urinating	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleed	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<u>RHEUMATOLOGY</u>		
<u>NECK</u>			Swelling of joints of hands	<input type="checkbox"/>	<input type="checkbox"/>
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpable mass	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<u>PSYCHIATRY</u>		
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
<u>BREASTS</u>			Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Palpable mass	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Nipple Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Ever under psychiatrist care	<input type="checkbox"/>	<input type="checkbox"/>
Breast Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<u>FOR WOMEN</u>	<u>Yes</u>	<u>No</u>
<u>PULMONARY</u>			Painful periods	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Non-productive Cough	<input type="checkbox"/>	<input type="checkbox"/>	Mid cycle bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Cough with Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	Hormone replacement therapy	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Ever had abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>
<u>CARDIOVASCULAR</u>			Ever had abnormal Mammo	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain at rest	<input type="checkbox"/>	<input type="checkbox"/>	Get period every _____ days		
Chest Pain with exertion	<input type="checkbox"/>	<input type="checkbox"/>	Last menstrual period: _____		
Shortness of breath			Last Mammogram : _____		
with exertion	<input type="checkbox"/>	<input type="checkbox"/>	Last PAP test : _____		
Lying flat	<input type="checkbox"/>	<input type="checkbox"/>			
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>			
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>			