**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_  
Cell: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status**: M S D W **Hand Dominance**: R or L

***Responsible Party if patient is a minor***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_  
Cell: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[Primary Insurance]***

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claims Address

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID Group No. Effec. Date Copay

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[Secondary Insurance]***

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claims Address

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID Group No. Effec. Date Copay

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[Please complete IF Workers Compensation for claims billing purposes]***

Did your injury happen on the job? Yes No **if yes,** on what date did the injury occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you report the accident to your employer? Yes No

Employer Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjusters Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of emergency contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release Medical Information to**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Dr**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Dr.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts at the time services are rendered unless other payment arrangements have been made. Any outstanding balances that are turned over to our collections agency will have a 33% increase to cover any administrative costs. \_\_\_\_\_\_\_\_\_\_ (**initial**)

I understand that I will be charged a $25 fee for any administrative paperwork, disability forms, FMLA, copies of medical records, etc…\_\_\_\_\_\_\_\_\_\_\_ (**initial**)

I understand that I will be charged $25 for any appointments that I miss or do not reschedule 24 hours in advance.

\_\_\_\_\_\_(**initial**)

Should it be decided that surgery is necessary I understand that I will be required to pay $300 prior to the procedure, depending on my insurance deductible and co-insurance \_\_\_\_\_\_\_\_\_\_\_ (**initial**)

Should it be required that a brace, splint or other durable medical equipment is prescribe by the physician, I understand that due to sanitary reason the item is non-returnable. I also understand that these items may not be covered by my insurance company. \_\_\_\_\_\_\_\_\_\_ (**initial**)

I, the undersigned, hereby consent to the following Treatment:

* Administration and performance of all treatments
* Administration of any needed anesthetics
* Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
* Use of prescribed medication
* Performance of diagnostic procedures/tests and cultures
* Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I consent to release my medication history and to have the same information gathered from any other prescribing providers.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Dr. Stuart M. Hilliard** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Dr. Stuart M. Hilliard** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. I may request a full copy of the Notice of Privacy Practices should I desire to have one.

Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS**: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Dr. Stuart M. Hilliard.**

I acknowledge that I have been given, upon request, the **North Texas Hand Center, P.A.** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_

A photocopy of this consent shall be considered as valid as the original.

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

**HEIGHT**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WEIGHT**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT COMPLAINT**: (Please list in order which problem bothers you the most)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**: (Please list all. Example- Diabetes, High blood pressure, Rheumatoid Arthritis, Ect.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SURGICAL HISTORY**: (Please list ALL surgeries)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CURRENT DAILY MEDICATIONS**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PREFERRED PHARMACY/LOCATION:**

**MEDICATION ALLERGIES**: (Include reaction):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU EVER HAD AN ALLERGIC REACTION TO THE FOLLOWING**: **YES OR NO**

(Include reaction)

**FOODS:**

SHELLFISH NUTS EGGS

**ENVIRONMENTAL:**

TOPICAL IODINE ADHESIVES LATEX TAPE

**HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING**:

HEPATITIS A HEPATITIS B HEPATITIS C HIV/AIDS TUBERCULOSIS

**TOBACCO USE**:

CURRENT DAILY SMOKER FORMER SMOKER SMOKELESS TOBACCO USE

YEARS SMOKED:\_\_\_\_\_\_\_\_\_

PACKS PER DAY:\_\_\_\_\_\_\_\_\_

**ALCOHOL USE**:

NEVER OCCASIONAL/ SOCIAL MODERATELY HEAVY

**MARITAL STATUS**:

SINGLE MARRIED WIDOWED SIGNIFICANT OTHER

**EMPLOYMENT**:

UNEMPLOYED HOMEMAKER FULL- TIME PART- TIME RETIRED

**DOES YOUR JOB REQUIRE REPETITIVE USE OF YOUR HANDS?** YES OR NO

**Review of Systems Checklist**

**Please circle ONLY the symptoms you have experienced in the past two weeks**

**General:**

fatigue fever weakness headache (chronic) weight loss weight gain

sleep disturbance

**Eyes:**

drainage from eyes Blurred or double vision dry eyes

Glasses or contacts

**Ear, Nose, Throat, and Neck:**

hearing loss nasal congestion nasal drainage sore throat dizziness vertigo

sinus problems difficulty swallowing snoring

**Cardiovascular:**

chest pain/ angina cold extremity edema lightheadedness murmur palpitations

reduced exercise tolerance fainting

**Respiratory:**

cough dry cough chest tightness difficulty breathing wheezing

short of breath

**Gastrointestinal:**

abdominal pain nausea vomiting diarrhea jaundice rectal bleeding heartburn

ulcers constipation

**Genitourinary:**

bloody urine increased frequency incontinence difficulty urinating

**Musculoskeletal:**

arm pain back pain deformity elbow pain finger pain gait abnormality

hand pain joint crepitus joint redness joint swelling joint pain joint warmth

neck pain numbness shoulder pain stiffness weakness wrist pain

**Skin:**

bruising insect bites scarring brittle nails nail changes nail deformity

nail discoloration nail thickening new lesions itching rash skin changes

**Neurological:**

memory loss impaired balance weakness confusion dizziness

motor paralysis neurological symptoms seizure numbness

**Psychiatric:**

anxiety depression psychiatric or emotional difficulty

substance abuse trying to decrease substance abuse alcohol or drug addiction

**Endocrine:**

cold intolerance prolonged healing heat intolerance high blood sugar

low blood sugar increased thirst increased appetite increased urination

**Hematologic/ Lymphatic:**

easy bleeding prolonged bleeding blood clotting problems easy bruising

recurrent infections prolonged infection slow wound healing

**Allergic/ Immunologic:**

allergies (seasonal) eye itching eye redness eye swelling hives nasal congestion

nasal swelling