

**Health Care Consumer Questionnaire**

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The **Health Care Consumer (HCC) - Health Care Provider (HCP)** relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.*

<b>Patient Name</b>	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Date of Birth</b> (MM/DD/YYYY)	<b>Social Security Number</b>
<b>Reason for Visit</b>	

*If the person completing this form is not the patient, please write your name, your relationship to the patient, and why the patient is unable to complete the form.*

<b>Name</b>	<b>Relationship to Patient</b>
<b>Reason</b>	

<b>Health Care Consumer's Address</b>	<b>Phone</b>
	Home
	Work
	Cell

<b>Emergency Contact (Address and Phone)</b>	<b>Phone</b>
	Home
	Work
	Cell

<b>Insurance Information</b>	<b>Phone</b>
<b>Policy #</b>	

<b>Additional, or Secondary Insurance Company</b>	<b>Phone</b>
<b>Policy #</b>	

<p><b>Have you designated a Durable Power of Attorney for Health Care?</b></p> <p><i>If yes, please provide a copy for your health care provider.</i></p> <p><b>Do you have any religious or cultural beliefs that may impact your health care? If yes, describe</b></p> <p><b>I best learn new information by:</b> <input type="checkbox"/>Verbal Instruction <input type="checkbox"/>Written Instruction <input type="checkbox"/>Handouts <input type="checkbox"/>Pictures</p> <p><b>Level education completed</b> <input type="checkbox"/>&lt;6<sup>th</sup> grade <input type="checkbox"/>6<sup>th</sup> – 9<sup>th</sup> grade <input type="checkbox"/>12<sup>th</sup> grade <input type="checkbox"/>1-4 years college <input type="checkbox"/>&gt;4 years college</p> <p><b>I understand English well</b> <input type="checkbox"/>Yes <input type="checkbox"/>No <b>If NO, please specify the language you prefer</b></p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
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Health Care Consumer Questionnaire

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Names and Phone Numbers for Health Care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months), or from whom you have received prescriptions.**

	Contact #	
	Contact #	
	Contact #	
	Contact #	
	Contact #	
	Contact #	

**Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.**

Medication Name	Dose	Last taken	Medication Name	Dose	Last taken

**Please list and describe allergic reactions you have had to food, medications or insect stings.**

Check if you are you allergic to  Shellfish \_\_\_\_\_  IV Contrast Dye \_\_\_\_\_  Penicillins \_\_\_\_\_

Please list other Food, Medication or Insect Allergies	Describe your reaction

**Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience.)**

Occupation	Start Date	Stop Date	Responsibilities

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**Have you ever been exposed to known cancer causing agents or inhalation hazards?** Yes No

Examples: asbestos, paints, aniline dyes, chemicals, silica, etc.

Agent	Exposure time	Problems related to exposure

**Please describe your hobbies.**


**Have you traveled, in the past 1 year?** Yes No

Travel destinations OUTSIDE the United States	Dates spent at this destination

Travel destinations INSIDE the United States	Dates spent at this destination

**Exercise History**

Do you exercise? Yes No If yes, describe how long and how often you exercise on average each week


**History of Falls**

In the past 12 months, have you fallen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how many times?	
If yes, have you ever broken bones, or sustained an injury, as a result of falling?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Vaccination History** Have you ever had any of the following vaccinations?

Vaccine		Date of last vaccination
Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No	
BCG	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Varicella	<input type="checkbox"/> Yes <input type="checkbox"/> No	
HPV (Gardasil)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Tobacco Use History		If yes, describe	
Have you ever smoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# packs per day X	# years
Have you chewed tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you smoked pipes or cigars?	<input type="checkbox"/> Yes <input type="checkbox"/> No	#cigars or pipe bowls per	<input type="checkbox"/> Day <input type="checkbox"/> Week
Have you quit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When	
Have you consider quitting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you set a date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you tried quitting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What was the longest time you quit?	

Alcohol Use History		If yes, describe	
Do you now, or did you once, regularly drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# drinks per	<input type="checkbox"/> Day <input type="checkbox"/> Week
<b>1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor (80 proof) or 5 oz wine</b>			
Have you ever "blacked out" due to alcohol intake?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you had a drink to prevent the "shakes", "sweats", or developing other problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been arrested or ticketed for DUI (Driving Under the Influence)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you been involved in any motor vehicle accidents in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Recreational Drug Use History	
Do you now use, or have you ever used, drugs for recreational purposes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, check all that apply <input type="checkbox"/> Amphetamines <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Heroin <input type="checkbox"/> Inhalants <input type="checkbox"/> LSD	
Describe the method of delivery you chose <input type="checkbox"/> Ingestion <input type="checkbox"/> Injection <input type="checkbox"/> Inhalation	
Have you quit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever taken drugs to prevent the "shakes", "sweats", or developing other problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a problem with addiction to prescription pain medication or benzodiazepines (like Valium, Xanax, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Hepatitis, HIV and STD risk factors	
Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do you practice birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What birth control method do you use? Check all that apply <input type="checkbox"/> Condoms <input type="checkbox"/> Diaphragm <input type="checkbox"/> IUD (Intrauterine Device) <input type="checkbox"/> Birth Control Pills, Patches, Implants	
How many sexual partners have you had in the past 1 year? <i>Specify here</i>	
Have you ever had sex with a person who is the same gender as yourself, bisexual, or anyone who performs sexual favors in exchange for money or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you EVER been diagnosed with a sexually transmitted disease "STD" (like syphilis, gonorrhea, chlamydia or HIV), or were you exposed to a STD during childbirth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any tattoos or body piercings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received any transfusions of blood or blood products?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Seatbelt Use	
Describe your seatbelt use when you are driving, or a passenger in a vehicle <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> About half the time <input type="checkbox"/> Rarely <input type="checkbox"/> Never	

Firearm Safety	
Do you keep firearms in your place of residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, are they kept in locked compartments, or do they have safety locks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can you perform your own hygiene, dressing, cooking and shopping needs independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been in a relationship where you were threatened, hurt or afraid?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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**Prior Diagnostic Tests** Have you ever had any of the following exams?

Test	Response	Approximate date and Reason
PAP Smear	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Prostate Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
EGD (Esophageal endoscopy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
EKG	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiac stress test	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ECHO	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chest x-ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CT "CAT" scan of chest	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pulmonary function test	<input type="checkbox"/> Yes <input type="checkbox"/> No	
EEG	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bone density test	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Female Patients Only**

	Response	Descriptions
Have you ever been pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
# of pregnancies		
# Live Births		
# Miscarriages, Abortions		
Your age at onset of menstruation		
Your age at onset of menopause	<input type="checkbox"/> NA	
Have you ever taken birth control pills, or used patches or implants? If yes, how long	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever used hormone replacement therapy? If yes, how long	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you ever have an IUD (Intrauterine Device) implanted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you had an IUD, was it removed? If yes, when	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Surgical History**

Surgery or Procedure	Date of Procedure	Name of Provider Performing Procedure

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**Past Medical History** Please check all that apply.

<b>Adrenal Dysfunction</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Irregular Heart Rhythm</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Alzheimer</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Kyphosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Amyotrophic Lateral Sclerosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Liver Dysfunction</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anorexia or Bulimia</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Kidney Failure, or Dysfunction</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anxiety Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Malignancy</b> If yes, describe below	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Arteriovenous Malformations (AVMs)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Arthritis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Mania</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Asthma</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Muscular Dystrophy</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Autoimmune Disease</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Myocardial Infarction (Heart Attack)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Bipolar Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Narcolepsy</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Bleeding Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Obstructive Sleep Apnea</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cataracts</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Organ Transplant</b> If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cerebrovascular Accident (Stroke)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Chemotherapy</b> If yes, state when	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Osteoporosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>Pancreatitis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Claudication</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Periodic Limb Movement Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Clotting Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Peripheral Artery Disease</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Congenital Heart Defects</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Personality Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Coronary Artery Disease</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pituitary Dysfunction</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>COPD</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Polycystic Ovarian Syndrome</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cystic Fibrosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pulmonary Artery Hypertension</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Depression</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pulmonary fibrosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diabetes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Radiation Therapy</b> If yes, explain	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dialysis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Eclampsia or Pre-eclampsia</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Recurrent Infections</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Endocarditis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Restless Leg Syndrome</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Endometriosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Sarcoidosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>End Stage Renal Disease</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Schizophrenia</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Erectile Dysfunction</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Scleroderma</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Esophageal Dysfunction</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Scoliosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Fibromyalgia</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Seizure Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Gallstones</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Sickle Cell</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Gastritis or Gastric Ulcers</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Sjogren</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>GERD (reflux problems)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Skin Disorders (Psoriasis, Acne)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Glaucoma</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Thalassemia</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Heart or Valve Defects</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Thrombocytopenia</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hemochromatosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Thrombophilia</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hemorrhoids</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Transfusions</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hepatitis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Tuberculosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HIV or AIDS</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, have you been treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hypertension</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Urinary retention or urgency</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hyperthyroidism</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Vasculitis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hypotension</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Visual defects</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hypothyroidism</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Vocal cord dysfunction/paralysis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Inflammatory Bowel Disease</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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**Review of Systems** In the last 6 months, have you experienced any of the following symptoms? Respond to each.

**Constitutional**

- Weight Loss or Gain  Yes  No
- Appetite changes (increased or decreased)  Yes  No
- Fatigue, profound and impairs daily function  Yes  No
- Fever  Yes  No
- Shakes/sweats from lack of alcohol or drug  Yes  No

**Eyes**

- Eye pain or drainage  Yes  No
- Visual changes  Yes  No
- Dry, irritated eyes  Yes  No

**ENT/Mouth**

- Ear pain or drainage  Yes  No
- Frequent sinus infections  Yes  No
- Hearing changes or loss  Yes  No
- Nosebleeds  Yes  No
- Dizziness  Yes  No

**Respiratory**

- Blood in your sputum  Yes  No
- Chest tightness  Yes  No
- Cough lasting >1 month, productive or not  Yes  No
- Shortness of breath  Yes  No
- Wheezing  Yes  No
- Chest pain with inhalation or coughing  Yes  No

**Cardiovascular**

- Chest pain or heaviness  Yes  No
- Palpitations  Yes  No
- Fainting or near fainting spells  Yes  No
- Swelling of feet or legs  Yes  No
- Shortness of breath lying flat in bed  Yes  No

**Gastrointestinal**

- Abdominal pain  Yes  No
- Blood in your stool  Yes  No
- Constipation  Yes  No
- Diarrhea or Food Intolerance  Yes  No
- Heartburn or Indigestion  Yes  No
- Vomiting or nausea lasting for >1 day  Yes  No
- Swallowing difficulty  Yes  No

**Psych**

- Anxiety without clear explanation  Yes  No
- Sadness lasting for days or weeks  Yes  No
- Hearing voices  Yes  No
- Thoughts of hurting yourself  Yes  No
- Thought of hurting others  Yes  No
- Fear of people, places or things  Yes  No

**Genitourinary**

- Blood in your urine  Yes  No
- Menstrual changes  Yes  No
- Urinating that is painful or difficult  Yes  No
- Erection problems  Yes  No
- Vaginal discharge or bleeding  Yes  No

**Musculoskeletal**

- Broken bones  Yes  No
- Joint pain or swelling  Yes  No
- Muscle aches  Yes  No
- Muscle weakness  Yes  No
- Back pain  Yes  No

**Skin/Breasts**

- Masses or lumps  Yes  No
- Nipple discharge  Yes  No
- Rashes or nonhealing ulcers  Yes  No

**Neurologic**

- Seizures  Yes  No
- Coughing or choking with swallowing  Yes  No
- Excessive daytime sleepiness  Yes  No
- Extremity pain or burning sensations  Yes  No
- Hallucinations  Yes  No
- Numbness or tingling  Yes  No
- Difficulty falling asleep, staying asleep  Yes  No

**Endocrinologic**

- Hair loss  Yes  No
- Frequent urination  Yes  No
- Increased thirst  Yes  No
- Heat or cold intolerance  Yes  No

**Heme/Lymph**

- Bleeding from gums or nose  Yes  No
- Unexplained bruising  Yes  No
- Night Sweats  Yes  No
- Swollen, painful lymph nodes  Yes  No

**Allergy/Immun**

- Watery eyes  Yes  No
- Runny nose  Yes  No
- Food intolerance  Yes  No
- Frequent skin sores  Yes  No

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**Family Medical History**

(M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather, M in front = Maternal P = Paternal)

Medical Problem	Family Members Affected
	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> B <input type="checkbox"/> S <input type="checkbox"/> So <input type="checkbox"/> D <input type="checkbox"/> M-GM <input type="checkbox"/> M-GF <input type="checkbox"/> P-GM <input type="checkbox"/> P-GF
	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> B <input type="checkbox"/> S <input type="checkbox"/> So <input type="checkbox"/> D <input type="checkbox"/> M-GM <input type="checkbox"/> M-GF <input type="checkbox"/> P-GM <input type="checkbox"/> P-GF
	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> B <input type="checkbox"/> S <input type="checkbox"/> So <input type="checkbox"/> D <input type="checkbox"/> M-GM <input type="checkbox"/> M-GF <input type="checkbox"/> P-GM <input type="checkbox"/> P-GF
	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> B <input type="checkbox"/> S <input type="checkbox"/> So <input type="checkbox"/> D <input type="checkbox"/> M-GM <input type="checkbox"/> M-GF <input type="checkbox"/> P-GM <input type="checkbox"/> P-GF
	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> B <input type="checkbox"/> S <input type="checkbox"/> So <input type="checkbox"/> D <input type="checkbox"/> M-GM <input type="checkbox"/> M-GF <input type="checkbox"/> P-GM <input type="checkbox"/> P-GF
	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> B <input type="checkbox"/> S <input type="checkbox"/> So <input type="checkbox"/> D <input type="checkbox"/> M-GM <input type="checkbox"/> M-GF <input type="checkbox"/> P-GM <input type="checkbox"/> P-GF
	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> B <input type="checkbox"/> S <input type="checkbox"/> So <input type="checkbox"/> D <input type="checkbox"/> M-GM <input type="checkbox"/> M-GF <input type="checkbox"/> P-GM <input type="checkbox"/> P-GF

**Referral Information – We would appreciate learning how you heard about us? Check one, please**

- Another physician, nurse practitioner or physician assistant?  
If so, please specify who:
- Family member or friend who is a patient of this clinic
- Family member or friend who is NOT a patient of this clinic
- Sign outside your office
- Billboard Ad
- Media Ad *Please specify*  Television  Radio  Newspaper Ad
- Hospital referral service
- Phone book
- Internet
- Other, *please specify*

**Additional Information that you feel may be helpful for your health care provider to know.**

**Health Care Provider Notes**