FOOTHILLS COMMUNITY HEALTH CARE

Welcome to Your Medical Home

Wellness Within Reach

Foothills Community Health Care (FCHC) will be your medical home. As your medical home, we will keep track of all labs, x-rays, referrals, and medications as well as coordinate care between your health care team. FCHC will also remind you of important health screenings. FCHC will also help you set goals for your health and help you track how well you meet those goals.

As a patient, your responsibility will be to provide complete and thorough information about your health and to notify any other healthcare facility that FCHC is your medical home. If you find yourself in the Emergency Department or in the hospital, please let them know that FCHC is your medical home.

In a patient centered medical home organization, patients are encouraged to choose their primary care provider. Once this choice is made, our staff will try to schedule all your appointments with the provider you selected. The advantage for you is that you have a provider you like working with and one that is specifically responsible for coordination of your care. The provider will also ensure you receive all recommended preventative care and that any problems uncovered are followed up in a timely manner.

There may be times when it is in your best interest to see a different provider for timeliness or urgency. Your primary care provider will have updated information about these visits to ensure that you receive continuity of care. Ask the front desk staff for a Patient Transfer Form if you would like to change providers within FCHC.

You can find out about our providers at www.myfchc.org

PLEASE BRING THE FOLLOWING ITEMS TO YOUR APPOINTMENT:

- ☐ Photo ID (Gov't Issued ID Card)
- ☐ Social Security Card (If applicable)
- ☐ Medicare Card, Medicaid Card, Rx Plan Card, Third Party Commercial Insurance (Co-Pay if Required)
- ☐ Immunization (Shot) Record *Required for pediatric patients
- ☐ Current Medicine Bottles

FCHC offers a sliding fee discount based on family size and income with co-payments starting at $20. You may qualify even if you have insurance.

To determine whether you qualify for a discount, please provide proof of income for each person living in the household who is 18 years of age or older. A nominal fee may be charged for the office visit and will vary based upon family size and household income. Charges for service in addition to an office visit may be due upon check out or billed to you. (Ex: Charges for labs, procedures, etc.)

Proof of income, which may include:

- Three (3) recent pay stubs
- Statement from Unemployment Office
- Most recently filed tax return
- Statement from Social Security Administration

Appointment Scheduling & No-Show Policy

We will try to schedule your appointment at a date and time most convenient for you. As a courtesy, we attempt to contact every Patient to remind them of their appointment. However, it is the responsibility of the Patient to arrive for their appointment on time. If you are more than 15 minutes late for your scheduled appointment, it may be necessary to reschedule your appointment for a later date. If you are unable to keep a scheduled appointment, please call our office as soon as possible. ***Cancellations must be received 24 hours in advance.*** Failure to notify our office 24 hours in advance will be documented as a "No-Show". ***Three (3) "No Show" appointments within a 6-month period may result in being placed on a 12-month probationary period.*** During this time, we will not be able to schedule appointments for you. Any visits will be on a walk-in basis when time permits.

HOW TO CONTACT US:

Prescriptions & Messages

- *Controlled substances will not be written on your first visit.*
- Medical messages will be returned within 48 business hours.
- When leaving a message please leave your
  - Name, DOB, Phone number, and Reason for your call.
- Phone calls will be processed in-between patient visits.
- Please avoid leaving multiple messages as this may delay our response time.

After Hours

When the office is closed, you may call our regular phone number to be forwarded to our answering service. The service will take the necessary information and page the FCHC provider on call. You can expect a response within 30 minutes. ****Prescription refills will not be handled by the after-hours provider****

Patient Portal

24/7 Access to communicate with your provider, manage your appointments, view your medications and request refills, and pay your balance. Please request a one-time access code from the front desk either in person or over the phone.

Transfer of Records

Your medical history is important to allow us to provide the best care for our patients. The new patient packet includes a consent form for transferring your medical records to FCHC. Please complete this form and give it to the front desk staff on your first visit. This will help ensure we have what we need.

FCHC- Clemson

Monday, Wednesday, Thursday, Friday - 8am to 5:00pm
Tuesday 8am to 7pm
(Closed for Lunch: Noon – 1:00 pm Daily)
110 Liberty Drive, Suite 100 ▪ Clemson, SC 29631 ▪ (864) 722-0283

FCHC Easley	**FCHC - Anderson**
Monday – Friday 8:00 am to 5:00 pm	Monday - Friday- 8am to 5:00 pm
(Closed for Lunch: Noon – 1:00 pm Daily)	(Closed for Lunch: Noon – 1:00 pm Daily)
403 Hillcrest Drive, Suite E, Easley, SC 29640	1100 W. Franklin, St., Anderson, SC 29624
(864) 343-1220	(864) 224-0822

FOOTHILLS COMMUNITY HEALTH CARE

www.myfchc.org

Patient Registration Form

Parent(s) must bring child in for first visit. If legal guardian, you must provide proper proof of guardianship.

Social Security Number: _____-_____-_____ ***Prefix:*** _____ Miss _____ MR. _____ MRS. _____ MS.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Nickname: _____ **Suffix:** _____ Jr. _____ Sr. _____ II ____ III _____ IV

Date of Birth (MM/DD/YY) : _____/_____/_____ **Sex (Gender):** _____ *Female* _____ *Male*

Street Address: _____ **City:** _____ **Zip:** _____

Email: _____ **Cell Phone:** (_____) _____ - _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Emergency Contact: _____ **Phone Number:** _____

Best way to reach you: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Can FCHC send you text messages regarding upcoming appointments and results? ☐ Yes ☐ No

Preferred Pharmacy: Name _____ **Location** _____

Preferred Mail in Pharmacy: Name _____ **Location** _____

PLEASE MARK YOUR ANSWER

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner ☐ Legally Separated ☐ Unknown

Are you a U.S. Military Veteran? ☐ Yes ☐ No

Gender Identity: ☐ Male ☐ Female ☐ Transgender: Male/Female-to-Male ☐ Transgender: Female/Male-to-Female ☐ Choose not to disclose ☐ Other

Sexual Orientation: ☐Straight ☐Bisexual ☐ Lesbian or Gay ☐ Don't Know ☐ Something Else ☐ Choose Not to Disclose

Annual Household Income: ☐$0-$25,000 ☐$25,001-$50,000 ☐$50,001-$75,000 ☐$75,001-$100,000 ☐$100,000+ ☐Refuse to report

Size of Household:_____ ***Even with insurance if you qualify for the sliding fee scale you could lower your copayment and charges for the visit. See front staff for details ***

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐Unemployed ☐ None

Employer Name: _____ Employer Address: _____

City: _____ State: _____

Student: ☐Full-time ☐Part-time ☐ Not in School
Language: ☐ English ☐ Spanish ☐ French ☐Chinese ☐Sign Language ☐ Other ☐ Unreported ☐ Refused to Report

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black ☐ African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Refused to Report ☐ Other_____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unreported ☐ Refused to Report

Agricultural: ☐ Dependent of Migrant ☐ Dependent of Seasonal ☐ Migrant Worker ☐ Not Agricultural Worker ☐Seasonal Worker

Homeless: ☐Yes ☐No

If Yes: ☐ Public Housing ☐ Homeless Shelter ☐ Doubling Up ☐Transitional ☐ Street ☐ Other ☐Unknown

IN ORDER FOR US TO BILL YOUR INSURANCE COMPANY FOR SERVICES, YOU MUST PROVIDE A COPY OF YOUR INSURANCE CARD

PRIMARY INSURANCE INFORMATION- PLEASE BRING INSURANCE CARDS AND COPAYMENTS ON EVERY VISIT

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance company name field.

Subscriber's Name on Card: _____ DOB: _____ Relationship to patient_____

Sex: Female/ Male SS#: _____

If address and phone number are the same as the patient, please indicate same.

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Employer: _____

Insurance Company Name: _____ Phone: _____

Policy/Cert #: _____ Group #: _____ Effective Date: _____

SECONDARY INSURANCE INFORMATION- PLEASE BRING INSURANCE CARDS AND COPAYMENTS ON EVERY VISIT

Subscriber's Name on Card: _____ DOB: _____ Relationship to patient_____

Sex: Female/ Male SS#: _____

If address and phone number are the same as the patient, please indicate same.

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Employer: _____

Insurance Company Name: _____ Phone: _____

Policy/Cert #: _____ Group #: _____ Effective Date: _____

GUARANTOR INFORMATION

If 18 or older-you do not have to complete this section and will be listed as guarantor. The guarantor will be responsible for any balance due. Parent/ guardian presenting minor child for treatment will be listed as the guarantor.

Name: _____ Patient relation to guarantor: _____
Last First Middle
DOB: _____ SS#_____ Home Phone: _____ Cell Phone: _____
Mailing Address (if different from above):
_____City: _____State: _____ Zip: _____

How did you hear about us? _____

Authorization for pediatric patient to be brought in for treatment for Medical and/or Behavior Health Care by designee (applies to all pediatric patients ages >18)

<u>If legal guardian, you must provide proper proof of guardianship.</u>

I understand that I, Parent/ guardian, must bring my child to the first medical and/or Behavior Health appointment with a Foothills Community Health Care provider to give a complete medical history. Following the first visit, I give permission for the following individual(s) to bring my child to Foothills Community Health Care for medical and/ or Behavior Health care and treatment. I understand that by giving permission for this individual(s) to bring my child for medical and/ or Behavior Health, the individual(s) is fully authorized to consent to the medical and/or Behavior Health treatment prescribed by the Foothills Community Health Care provider.

Patient Name: _____ DOB: _____

In your absence, is there anyone authorized to seek medical treatment for your child? ☐ Yes ☐ No

If yes, please complete the following:

Alternate individuals that may bring child to FCHC for medical and/ or Behavior Health care and treatment:

Name	**Relationship**
_____	_____
_____	_____
_____	_____

_____

Print Parent Name **Date**

_____

Parent Signature **Date**

Patient Name: _____ Date: _____ FCHC Staff Signature: _____

Completion of this consent is necessary to offer services to a patient. Some items may not apply to your current situation; however, in order to provide comprehensive care during this visit and future visits we request that you complete this consent in its entirety. You have the privilege of revoking this consent, by providing written notice, at any time.

Consent for Medical and Behavioral Health Treatment

By initialing, I voluntarily consent to Medical and/or Behavioral Health treatment and the diagnostic procedures provided by Foothills Community Health Care and its associated physicians, clinicians and other personnel. I consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my provider. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to the result of treatments and examinations.

_____Initials

Notice of Privacy Practices Acknowledgment

I have received or read a copy of the Notice of Privacy Practices The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.myfchc.org

_____Initials

FINANCIAL RESPONSIBILITY

By initialing below, I understand that if I qualify for services through a grant funded program, such as the Sliding Fee Scale and/or the Department of State Health Services Family Planning (Title X) these resources are payers of last resort. Meaning that, if I currently or in the future have Medicare, Medicaid and/or third-party insurance, I may not be eligible for services under these grants. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the front office staff. If such changes have not been appropriately reported and if those changes in my status result in my ineligibility for services under a grant funded program at FCHC, I understand that I am fully responsible for the cost of services delivered by FCHC.

_____Initials

Assignment of Insurance Benefits

By initialing below, I understand and agree that health or behavioral health insurance coverage is an agreement between the insurance carrier and myself. I understand that Foothills Community Health Care will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized will be paid directly to Foothills Community Health Care. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I authorized Foothills Community Health Care to furnish information to insurance carriers concerning my illness and treatments.

I acknowledge my responsibility to pay for that care according to the fees established.

If the patient is a minor, I am the parent and/ or guardian of said patient and I agree that I am responsible for all services provided to the patient herein.

_____Initials

I understand that I am responsible for the cost of services delivered that are not covered by my insurance. I also understand that I may be responsible for my co-pay to be paid prior to me being seen by a health care practitioner.

_____Initials

Authorization for Release of Medical Information

Foothills Community Health Care is authorized to release any medical information required in the processing of applications or submission of information for financial coverage and further medical treatment. To include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

_____Initials

Authorized Individuals

By initialing, I authorize FCHC and medical staff to communicate and discuss my healthcare information with the following which may include information about my medical diagnosis, eligibility status and appointments with the contacts listed below. **I understand that by leaving spaces blank, I am indicating my choice to be "No Information," and I do not want any information released without my express consent.**

_____ _____ _____
Name Phone Number Relationship

□ Release of Records □ Health Care Proxy (person patient appoints to make healthcare decisions in their place) □ Patient Lives with contact □Communicate with Primary Caregiver □Communicate with Care Team □ Is this person your Next of Kin

_____ _____ _____
Name Phone Number Relationship

□ Release of Records□ Health Care Proxy (person patient appoints to make healthcare decisions in their place) □ Patient Lives with contact □Communicate with Primary Caregiver □Communicate with Care Team □ Is this person your Next of Kin

_____Initials

NO- SHOW LATE/ MISSED APPOINTMENT POLICY

We, at Foothills Community Health Care (FCHC), understand that sometimes you need to cancel or reschedule your appointment and there are emergencies. If you are unable to keep your appointment, please notify the office at least 24 hours prior to your appointment. To ensure that each patient is given the proper amount of time for their visit and to provide the highest quality of care, it is very important for each scheduled patient to attend their visit on time. We will try our best to schedule your appointment at the most convenient time possible. As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. If this is your first visit with FCHC we ask that you arrive 30 minutes prior to your appointment time to complete paperwork.

1) **If you are more than 15 minutes late for your scheduled appointment, you may be rescheduled for a later time or date.**
2) **If you are unable to keep a scheduled appointment, please call our office prior to your appointment so that we may care for someone else during that time. Cancellations must be received 24 hours in advance.**
3) **Failure to notify our office in advance, of the inability to keep an appointment, will be documented as a "No-Show" appointment.**
4) **If you have 3 "No-Show/Missed" appointments within a 6 month time frame, you may be placed on a 12 month probationary period. During this time we will not be able to schedule any appointments. Any visits will only be on a walk in basis as time permits.**

By initialing below, I understand and agree with Foothills Community Health Care's **No Show Late/Missed Appointment Policy** and understand my responsibility to plan appointments accordingly and notify FCHC appropriately if I have difficulty fulfilling my scheduled appointments.

_____Initials

Patient's Rights and Responsibilities

As a patient you have the right:

- To be treated with respect, including recognition of personal beliefs and values.
- To receive care in an environment that is committed to patient safety.
- To access care easily and in a timely fashion.
- To privacy and confidentiality.
- To coordination and continuity of your health care.
- To participate in your own healthcare decisions.
- To refuse treatment.
- To have information presented in terms that can be understood, which include treatment and care options.
- To change your provider, if desired.
- To be heard if you have a problem or complaint.

As a patient you have a responsibility:

- To provide complete medical information to your health care providers.
- To ask questions so that you have a clear understanding.
- To report any changes in your health.
- To understand your health issues and to follow any agreed upon plans and instructions for your care provided by your medical team.
- To keep scheduled appointments, or to reschedule in a timely manner.
- To respect the rights, privacy and confidentiality of other patients and clinic personnel.
- To be thoughtful and respectful of other patients and Foothills Community Health Care staff.
- To accept financial obligations and understand your health insurance benefits.
- Failure to adhere to the above rules and regulations may result in being discharged as a patient of our clinic.

By initialing below, I understand the Patient's Rights and Responsibilities Policy.

_____Initials

Patient Name: _____ DOB: _____ Date: _____
Patient Signature or Parent/Guardian if minor: _____ Relationship to Patient: _____
FCHC Staff Signature: _____ Date: _____

FCHC Clemson: Address: 110 Liberty Drive, Suite 100, Clemson, SC 29631 **Phone** (864) 722-0283 **Fax** (864) 722-0261

FCHC Easley: Address: 403 Hillcrest Drive, Suite E, Easley, SC 29640 **Phone:** (864) 343-1220 **Fax** (864)307-8870

FCHC Anderson: Address: 1100 W. Franklin Street, Anderson, SC 29624 **Phone:** (864) 224-0822 **Fax** (864) 261-8130

E-Fax (864) 643-4519- Results

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF HEALTH INFORMATION

My signature below hereby voluntarily authorizes the release or disclosure of my health information. (Only one patient per authorization)

Patient Name:	**DOB: SSN:**
I hereby authorize Foothills Community Health Care (FCHC) to:	☐ **RELEASE** and/or **EXCHANGE** specified information from my record to the following: **OR** ☐ **OBTAIN** specified information from the following:
Address, Phone Number or Fax Number: (of Person/ Facility/ Doctor's Office **Address:**_____ **Phone#:**_____ **Fax#:**_____	**NAME OF PERSON/ FACILITY/ DOCTOR'S OFFICE:** _____

II. The purpose of this disclosure is for continuity of care or (list reason) _____.

III. The information to be disclosed from my health record: (check the appropriate box (es) and circle documents to be released)

- ☐ **Office Visit Notes** Most Recent Only or Specifically: _____
- ☐ **Lab/Pathology Results** Most Recent Only or Specifically: _____
- ☐ **Radiology Reports** Most Recent Only or Specifically: _____
- ☐ **Immunization Records** Most Recent Only or Specifically: _____
- ☐ **Inpatient/ER Records** Most Recent Only or Specifically: _____
- ☐ **Birth Records** Most Recent Only or Specifically: _____
- ☐ **Behavioral Health Notes** Most Recent Only or Specifically: _____
- ☐ **Other:**_____

I also authorize the following sensitive information to be disclosed (check the applicable box (es) below)

- ☐ **Alcohol/Drug Abuse Treatment/Referral**
- ☐ **Sexually transmitted Disease**
- ☐ **HIV/AIDS-related treatment**
- ☐ **Mental Health (Other than Psychotherapy Notes)**

- I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 LISC 552a].
- I may revoke this authorization by notifying this practice in writing of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- This authorization expires on: _____

SIGNATURE OF PATIENT	DATE:
SIGNATURE OF AUTHORIZED REPRESENTATIVE (State relationship to patient) or Witness (if signature is thumbprint or mark	DATE:

Record Copy Fee Paid: _____
Witness Signature: _____ Date/Time:_____
Patient's Phone Number: _____ Patients, please allow 7-10 business days for the completion of this request

How to Contact Us

To express concerns, complaints, or grievances

- **Write to Address**

Foothills Community Health Care- Clemson

110 Liberty Drive, Suite 100
Clemson, SC 29631
Attention: Practice Manager

Foothills Community Health Care- Easley

403 Hillcrest Drive, Suite E
Easley, SC 29640
Attention Practice Manager

Foothills Community Health Care- Anderson

1100 W. Franklin Street
Anderson, SC 29624
Attention Practice Manager

- **Call our office**

You may call the Director of Operations at 864-722-0283 extension 409

- **Fill out a Patient Grievance Form**

If you feel were not treated properly, or if you feel you did not receive the treatment you deserve, please contact any FCHC staff for a Patient Grievance Form.

- **Fill out a Transfer Request Form**

If you wish to change your care to another FCHC provider, please ask the front desk staff or nursing staff for a Transfer Request Form.

PEDIATRIC PATIENT MEDICL HISTORY

Date	Child's Name	Nickname	DOB	M F

Birth History

Birth Weight _____ Preg# _____ Mom's age _____ Was the birth [ ] Vaginal? [ ] Cesarean? [ ] Early? [ ] Late?
If the birth was early, how many weeks early? _____ If Cesarean, why? _____
Did mother have any illnesses/problems with her pregnancy? [ ] No [ ] Yes Explain _____
Did baby have any problems right after birth [ ] No [ ] Yes Explain _____

Before mother knew she was pregnant or at any time during her pregnancy did she:
[ ] Smoke Cigarettes (amount) _____ [ ] Drink Alcohol (amount) _____
[ ] use "street" drugs (type) _____ [ ] Use Prescription Drugs (type) _____

Was initial feeding [ ] Breast Milk? [ ] Formula?

.....

Current and Past History

Is your child currently on any medication? [ ] Yes [ ] No Explain _____
Does your child have any serious or chronic illnesses [ ] Yes [ ] No Explain _____
Has your child had serious injuries or accidents? [ ] Yes [ ] No Explain _____
Has your child had any surgeries? [ ] Yes [ ] No Explain _____
Has your child ever been hospitalized? [ ] Yes [ ] No Explain _____
Is your child allergic to any medications? [ ] Yes [ ] No Explain _____
Has your child ever reacted to immunizations? [ ] Yes [ ] No Explain _____

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia [ ] Yes [ ] No Explain _____
Nasal allergies or eczema [ ] Yes [ ] No Explain _____
Frequent ear infections or sore throat [ ] Yes [ ] No Explain _____
Problems with ears or hearing [ ] Yes [ ] No Explain _____
Problems with eyes, vision or teeth [ ] Yes [ ] No Explain _____
Frequent headaches or other neurologic problems [ ] Yes [ ] No Explain _____
Frequent abdominal pain [ ] Yes [ ] No Explain _____
Constipation requiring doctor visits [ ] Yes [ ] No Explain _____
Bladder/Kidney problems or bedwetting [ ] Yes [ ] No Explain _____
Any heart problems/murmur [ ] Yes [ ] No Explain _____
Anemia or bleeding problems [ ] Yes [ ] No Explain _____
Thyroid or other gland problem [ ] Yes [ ] No Explain _____
Diabetes [ ] Yes [ ] No Explain _____
ADD/ADHD [ ] Yes [ ] No Explain _____
Mental Health Issues [ ] Yes [ ] No Explain _____
Use of drugs or alcohol [ ] Yes [ ] No Explain _____

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Household Information

Please List all Those Living in the Child's House:

Name Relationship to Child DOB

_____

_____

_____

_____

_____

Are there siblings not listed above? If so, please list their full names and ages and where they live

_____

_____

Child Care: _____

Smokers in household? [ ] Yes [ ] No

.....

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	[ ] Yes	[ ] No	Who_____	Comments _____
Allergies	[ ] Yes	[ ] No	Who_____	Comments _____
Asthma	[ ] Yes	[ ] No	Who_____	Comments _____
Birth Defects	[ ] Yes	[ ] No	Who_____	Comments _____
Blood Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Bone Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Cancer	[ ] Yes	[ ] No	Who_____	Comments _____
Diabetes	[ ] Yes	[ ] No	Who_____	Comments _____
Endocrine Disease	[ ] Yes	[ ] No	Who_____	Comments _____
Ear/Nose/Throat Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Eye Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Gastrointestinal Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Heart Disease	[ ] Yes	[ ] No	Who_____	Comments _____
High Blood Pressure	[ ] Yes	[ ] No	Who_____	Comments _____
High Cholesterol	[ ] Yes	[ ] No	Who_____	Comments _____
Immune Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Joint Problems	[ ] Yes	[ ] No	Who_____	Comments _____
Kidney Disease	[ ] Yes	[ ] No	Who_____	Comments _____
Liver Disease	[ ] Yes	[ ] No	Who_____	Comments _____
Lung Disease	[ ] Yes	[ ] No	Who_____	Comments _____
Migraine Headaches	[ ] Yes	[ ] No	Who_____	Comments _____
Metabolic Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Obesity	[ ] Yes	[ ] No	Who_____	Comments _____
Seizure Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Skin Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Stroke History	[ ] Yes	[ ] No	Who_____	Comments _____
Thyroid Disorders	[ ] Yes	[ ] No	Who_____	Comments _____
Mental Health History	[ ] Yes	[ ] No	Who_____	Comments _____
Other Medical History	[ ] Yes	[ ] No	Who_____	Comments _____