To Patients of Dr. Moore:

Please read the following very carefully and sign before coming to the appointment. Your signature at the bottom of the page will indicate that you have read, understand, and agree to adhere to these policies.

1. All Professional Fees are due and payable at the time of service. These charges are the total responsibility of the patient. Please plan to make payment for your charges at the end of each appointment.

2. Cancellation of an appointment must be done 24 hours before the appointment time, during office hours, between 10:00 a.m. and 5:00 p.m. This allows for the scheduling of another patient in that time slot. Any appointment not handled in this manner will be charged at the full amount of the normal office fee.

3. Insurance is billed as a courtesy by this office and cannot be counted upon as payment for services. This, again, is the responsibility of the patient.

4. If you have need of special services, such as a written progress report of your care, etc., this must be done in writing and given a reasonable amount of time for the completion thereof, prior to the date needed. Any special requests will be the exception and not the rule.

I, the undersigned patient, do hereby agree to adhere to and follow the requirements as set out above. I understand that these policies will not be considered flexible without the prior consideration and permission of Stephanie Moore, PsyD and with an additional signed agreement between Dr. Moore and me.

DATE: __________ PATIENT'S SIGNATURE: ________________

DATE: __________ WITNESSED: _________________________
Stephanie Moore, PsyD, ABPN
Clinical Associate Professor, UC Irvine, Department of Neurology

Request for Confidential Handling of Health Information, Consent for a Neuropsychological Assessment, Authorization to bill insurance, Understanding ultimate responsibility for payment resides with the Examinee and/or Patient.

1. I ___________________________ authorize and request that Stephanie Moore, PsyD, ABPN licensed Psychologist, carry out psychological/neuropsychological evaluation and/or diagnostic procedures, which now or during the course of my care as a patient, are advisable. I also understand that the purpose of these procedures will be explained to me and be subject to my agreement.

I have read and fully understand the consent form.

________________________________________________________________________
(Signature)  (Date)

________________________________________________________________________
(Witness Signature)  (Date)

2. I, __________________________________________ request that
(Print First and Last Name of patient/recipient)

Stephanie Moore, PsyD handle my confidential health information in the following way:

3. Please describe means by which you prefer to receive your health information or circle the methods you approve of below:

US mail, telephone call, e-mail, fax, and/or other:

All reasonable requests to receive communication of your health information by alternative means will be granted.

B. I hereby assign Stephanie Moore, PsyD all payments for medical services rendered to me or my dependents. I understand that I am fully responsible for any outstanding balance regardless of my insurance coverage.

________________________________________________________________________
(Signature)  (Date)
AUTHORIZATION OF PROTECTED INFORMATION

1. I authorize my psychologist, Stephanie Moore, PsyD, ABPN and/or her administrative and clinical staff to release (circle): Records and/or Neuropsychological Evaluation. This information should only be released to:

   Family: ________________________________________________________________

   Physicians: ____________________________________________________________

2. I am requesting my psychologist to release this information for the following reasons, and subject to the following limitations: (“At the request of the individual” is all that is required from the patient if he/she does not desire to state a specific purpose.)

   Circle: At my request or other reason: ________________________________

3. This authorization shall remain in effect. Circle either:

   Until a specific date: __________________________ or Dr. Moore is notified by Mail.

4. I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my psychologist’s office address. However, my revocation or modification will not be effective until my psychologist receives it.

5. I understand that my psychologist generally may not condition psychological services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in Sections I through III of the Notice form provided by my psychologist, or a disclosure that is otherwise not permitted by law. I understand that even if the authorization would not involve impermissible disclosures, my psychologist may not condition treatment upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of PHI for that research; or 2) the psychological services are provided to me for the purpose of creating health information for a third party.

6. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

   Signature of Patient __________________________ Date __________________________

   (If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.)

A XEROX COPY OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL
ADULT NEUROPSYCHOLOGICAL HISTORY

Name: _______________________________________ Date: _____________________

Address (Street, City, Zip): _________________________________________________

Examinee’s Telephone Number: (H):_________________ W): _____________________

Age: _____ Date of Birth: ____________ Sex: ____ Years of Education: _________

Height: _________ Weight: _______ Hair Color: ________ Eye Color: ___________

Ethnic/Racial Background: ________________________ Religion: _________________

Name of Referring Physician, Friend: _________________________________________

Briefly describe your problem _______________________________________________

________________________________________________________________________

________________________________________________________________________

What specific questions would you like answered by this evaluation?

1. ______________________________________________________________________

2. ______________________________________________________________________

3. ______________________________________________________________________

This form has been completed by: ____________________________________________

If not completed by the examinee, please provide the following information:

Name: _________________________________ Relationship to Examinee: __________

Address: ________________________________________________________________

Telephone Number: (H) ___________________________ (W) ____________________
DEVELOPMENTAL HISTORY

4. You were born: on time ___ prematurely ___ late ___
5. Your weight at birth: ___ pounds ___ ounces

6. Mother’s weight during pregnancy: ___ pounds

7. Were there any problems associated with your birth (such as oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (i.e., need for oxygen, special equipment used, convulsions, illness, etc.). Yes ___ No ___
   If “yes” describe: _________________________________________________________

8. Check all that applied to your mother while she was pregnant with you:
   ___ Accident
   ___ Alcohol use
   ___ Cigarette smoking
   ___ Drug use (marijuana, speed, cocaine, LSD, etc.).
   ___ Flu/Influenza
   ___ Illness (toxemia, diabetes, high blood pressure, infection, Rh incompatibility)
   ___ Poor nutrition
   ___ Psychological problems (depression, mania, Schizophrenia, etc.)
   ___ Other problems: ______________________________________________________

9. List all medications prescribed or over-the-counter that your mother took while pregnant with you: ______________________________________________________

10. During her pregnancy, did your mother live near a polluted area (toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area)?

11. Rate your developmental progress as it has been reported to you by checking one:

<table>
<thead>
<tr>
<th></th>
<th>Early</th>
<th>Average</th>
<th>On time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Development</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. As a child did you have any of these conditions? If so, circle the condition.

<table>
<thead>
<tr>
<th>Condition</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Problems</td>
<td>Head Injury</td>
<td>Muscle Tightness/weakness</td>
</tr>
<tr>
<td>Clumsiness</td>
<td>Hearing Problems</td>
<td>Speech Problems</td>
</tr>
<tr>
<td>Developmental Delay</td>
<td>Hyperactivity</td>
<td>Vision Problems</td>
</tr>
<tr>
<td>Frequent Ear Infections</td>
<td>Learning Disability</td>
<td>Loss of Consciousness</td>
</tr>
</tbody>
</table>

Other problems? ____________________________
PAST MEDICAL HISTORY

13. Circle all conditions diagnosed *when you were a child* and indicate age, treatment provided and any other pertinent information:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age</th>
<th>Treatment</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain Infection/Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colds (excessive)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. As a child, were you exposed to excessive amounts of lead (e.g. Eating paint chips, living next to high concentrations of automobile exhaust fumes) or other toxic agents? Circle: Yes/No

If “yes” please explain: ____________________________________________________

15. As a child did you ever have an accident that required a hospital visit? Circle: Yes/No

If “yes” please describe: ____________________________________________________

16. List all medications that were regularly given to you as a child:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason for the Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CURRENT MEDICAL HISTORY

17. *Circle all that currently apply*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Reason for the Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS, ARC, HIV+</td>
<td>Parkinson’s disease</td>
</tr>
<tr>
<td>Allergies</td>
<td>Polio</td>
</tr>
<tr>
<td>Arteriosclerosis</td>
<td>Psychiatric problems</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Radiation exposure</td>
</tr>
<tr>
<td>Blood disorder</td>
<td>Senility (dementia)</td>
</tr>
<tr>
<td>Brain disease/infection</td>
<td>Stroke/ TIA</td>
</tr>
<tr>
<td>Cancer or chemotherapy</td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Venereal disease</td>
</tr>
<tr>
<td>Hazardous/Toxic exposure</td>
<td>Multiple sclerosis</td>
</tr>
</tbody>
</table>

Any other problems: ____________________________________________________
18. List all medications, over-the-counter drugs or herbs that you currently take, including the dosage and any side effects.

Please include both prescription and over-the-counter medications:

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Side-Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you take the medications as prescribed: circle YES or NO?

19. Do you have epilepsy or a seizure disorder: circle YES or NO

If “YES” circle the type with which you have been diagnosed:

<table>
<thead>
<tr>
<th>PARTIAL</th>
<th>GENERALIZED</th>
<th>UNCLASSIFIED TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple, partial (Jacksonian)</td>
<td>Absence (Petit Mal)</td>
<td></td>
</tr>
<tr>
<td>Complex Partial (psychomotor)</td>
<td>Myoclonic</td>
<td></td>
</tr>
<tr>
<td>Partial evolving into generalized</td>
<td>Clonic</td>
<td></td>
</tr>
<tr>
<td>Tonic-clonic (grand mal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atonic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have seizures and do not know what type, please describe them:

________________________________________________________________________
________________________________________________________________________

20. Have you ever experienced a head injury: circle YES or NO. Describe the circumstances and any problems you had afterwards:

________________________________________________________________________
________________________________________________________________________

Were you in a coma? Circle YES or NO. How long: _____________________________?

Last clear memory prior to injury: ________________________________?

First continuous memory after injury ________________________________?

21. Describe all hospitalizations you have had:

a. ________________________________________________________________

b. ________________________________________________________________

c. ________________________________________________________________
FAMILY HISTORY
The following questions deal with your biological mother, father, brothers, sisters:

MOTHER

22. If she is alive, what is her present age: _______________?

23. If deceased, her cause of death was: _____________________ at age: ________?

24. Has she ever had memory impairment __________________________?

25. Mother’s level of education: ____________________________________________?

26. Mother’s occupation __________________________________________________?

27. Does your mother have a known or suspected learning disability: circle YES or NO.

28. Describe your mother’s health history:
________________________________________________________________________

FATHER

29. If he is alive, what is his present age: ____________? If deceased, his cause of death was: _____________________ at age: ________?

30. Did your father ever have memory impairment? ___________________________?

31. Father’s occupation __________________________________________________?

32. Father’s level of education: ____________________________________________?

33. Father’s hobbies: ____________________________________________________?

34. Does your father have a known or suspected learning disability: circle YES or NO.

35. Describe your father’s health history:
________________________________________________________________________

36. What were the ages of your Mother: _____ Father: ______ when you were born?

37. Who raised you: (Check all who apply and at what ages)

<table>
<thead>
<tr>
<th>Biological parent(s)</th>
<th>Relatives</th>
<th>Foster parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological and stepparent</td>
<td>Adoptive parents</td>
<td>Institution</td>
</tr>
<tr>
<td>Others:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

38. What languages were spoken at home: Primary: _____ Secondary: ____
SIBLINGS:
39. How many brothers _________ and sisters _________ do you have?

40. Where are you in the birth order?

41. Are there any unusual problems (physical, academic, psychological) associated with any of your siblings? Circle YES or NO. If “YES” please describe:

_______________________________________________________________________

42. Please check all that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles).

<table>
<thead>
<tr>
<th>WHO</th>
<th>DESCRIBE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy</td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td></td>
</tr>
<tr>
<td>Left-handedness</td>
<td></td>
</tr>
<tr>
<td>Mental Retardation</td>
<td></td>
</tr>
<tr>
<td>Speech/Language Disorder</td>
<td></td>
</tr>
<tr>
<td>Auto-immune Disorder</td>
<td></td>
</tr>
<tr>
<td>Other major disease/disorder</td>
<td></td>
</tr>
</tbody>
</table>

NEUROLOGIC DISEASE
<table>
<thead>
<tr>
<th>WHO</th>
<th>DESCRIBE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease/senility</td>
<td></td>
</tr>
<tr>
<td>Huntington’s disease</td>
<td></td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td></td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td></td>
</tr>
<tr>
<td>ALS/ Lou Gehrig’s Disease</td>
<td></td>
</tr>
<tr>
<td>Down’s Syndrome</td>
<td></td>
</tr>
<tr>
<td>Other neurologic disease</td>
<td></td>
</tr>
</tbody>
</table>

PSYCHIATRIC ILLNESS
<table>
<thead>
<tr>
<th>WHO</th>
<th>DESCRIBE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td></td>
</tr>
<tr>
<td>Manic Depressive/Bipolar</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Personality disorder</td>
<td></td>
</tr>
<tr>
<td>Schizophrenic</td>
<td></td>
</tr>
<tr>
<td>Criminal/Violent Behavior</td>
<td></td>
</tr>
<tr>
<td>Other psychological Illness</td>
<td></td>
</tr>
</tbody>
</table>

PERSONAL HISTORY
Marital History:

43. Current status: Married ___ Single ___ Divorced ___ Widowed ___ Separated ___
44. Years married to current spouse: __________ 45. Number of times married: _______
46. If married, spouse’s name: ______________________ Spouse’s age: __________
46. Spouse’s occupation: __________________________
47. Spouse’s health: Excellent ____ Good ____ Poor ____

48. Not married, but living with someone: Yes ____ No ____
   His/her health: Excellent ____ Good ____ Poor ____
   His/her occupation: ____________________________________________

49. Names and ages of children:

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

_Educational History_

50. Highest grade completed or highest degree earned: ______________________
    Name of school in which education was received: ____________________

51. How would you describe your usual performance as a student?

<table>
<thead>
<tr>
<th>A &amp; B</th>
<th>Please describe any helpful information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>B &amp; C</td>
<td></td>
</tr>
<tr>
<td>C &amp; D</td>
<td></td>
</tr>
<tr>
<td>D &amp; F</td>
<td></td>
</tr>
</tbody>
</table>

52. Did you ever repeat a grade? Circle YES or NO. If “YES” what grade and for what reason? __________________________

53. Were you ever in any special classes or receive special services: YES or NO
    IF “YES” what grade ___ or age: ___ and what type of service: ________________?

54. Were you ever suspended or expelled from school: YES or NO. If so, please explain:

_____________________________________________________________

_Occupational History_

55. Current job title:

56. Salary: under $10,000___ $10,000-29,999___, $30,000-50,000___, over $50,000___

57. How long have you been at this job? __________________________________________

58. Current job responsibilities

59. List prior jobs, starting with the most recent:

<table>
<thead>
<tr>
<th>POSITION</th>
<th>LENGTH OF TIME ON THIS JOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
60. At any time while on the job, were you exposed to hazardous or noxious substances (e.g., lead, mercury, asbestos, radiation, solvents, pesticides, chemicals)? YES or NO. If “YES” please explain: ________________________________________________

Military History

61. Branch: ________
62. Discharge rank: ___________ Type of discharge: _______________
63. Major military duties: __________________________________________
64. List any physical injuries you had during military service: _______________
65. Were you exposed to any dangerous substances while in the military (e.g., Agent Orange, radiation, etc.)? Explain: ___________________________________________

Recreation

66. List the types of recreation that you enjoy (i.e., sports, games, TV, hobbies, etc.):
_______________________________________________________________________

Substance use history

Alcohol
67. I started drinking at age: ______________
68. I drink alcohol: Rarely/never ____ 1-2 days/week ____ 3-5 days/week ___ Daily ___
69. I used to drink but stopped on: date stopped _______________________________
70. Preferred type (s) of drinks: _____________________________________________
71. Usual number of drinks I have at a time: ____________________________________
72. My last drink was less than 24 hours ago ___ 24-48 hours ___ over 48 hours ____
73. Check all that apply:
   __ I can drink more than most people at my age and size before I get drunk.
   __ I sometimes get into trouble (fights, legal difficulties, problems at work, conflicts with family, accidents, etc.) after drinking.
   __ I sometimes black out after drinking.
   __ I sometimes drink in the morning.
   __ I have had a DUI

Cigarettes
74. I started smoking at age: __________ Stopped at age: __________
75. I currently smoke _____ cigarettes each day.

Drugs
76. Please check all the drugs you are currently using or have used in the past:

<table>
<thead>
<tr>
<th></th>
<th>FROM</th>
<th>AMOUNTS CONSUMED</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbiturates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine/Crack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogens</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opiates</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>PCP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list all other drugs used: _____________________________________________

77. Do you consider yourself dependent on any of the above drugs: YES or NO

78. Do you consider yourself dependent on any prescription drugs? YES or NO. Which prescription drugs: ______________________________________________________

79. Check all that apply:
_____ I have gone through drug withdrawal
_____ I have used I.V. drugs
_____ I have been in drug treatment. Year: ________ Where: ____________

Legal and Suicide History

80. Legal difficulties: (i.e., arrests, restraining orders, property damage, law suits, DUIs, etc.): _____________________________________________

81. History of suicidal behavior: YES or NO
   Suicide attempts: When _____ Describe _________________________________
   Suicidal Ideation/threat: When ____ Describe __________________________

Do you have suicidal thoughts now? YES or NO

82. Have you ever physically assaulted another person YES or NO. If “YES” please describe: _____________________________________________

83. Please list any recent stressors you have experienced (i.e., death of a loved one, divorce, unemployment, pregnancy, retirement, change of residence, etc.) __________

______________________________

12
Medical Testing

84. Check all the medical tests that have recently been completed and state any abnormal results:

<table>
<thead>
<tr>
<th>TEST</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiography</td>
<td></td>
</tr>
<tr>
<td>Blood work</td>
<td></td>
</tr>
<tr>
<td>Brain scan</td>
<td></td>
</tr>
<tr>
<td>CT scan</td>
<td></td>
</tr>
<tr>
<td>EEG</td>
<td></td>
</tr>
<tr>
<td>Lumbar puncture/spinal tap</td>
<td></td>
</tr>
<tr>
<td>MRI</td>
<td></td>
</tr>
<tr>
<td>Neurological office exam</td>
<td></td>
</tr>
<tr>
<td>PET scan</td>
<td></td>
</tr>
<tr>
<td>Physician’s office exam</td>
<td></td>
</tr>
<tr>
<td>Skull x-ray</td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td></td>
</tr>
<tr>
<td>Other testing results:</td>
<td></td>
</tr>
</tbody>
</table>

85. Identify the physician who is most familiar with your recent problems:
   Name: __________________________________________________________________
   Address; _________________________________________________________________
   Telephone: ______________________________________________________________
   Date of your last medical check-up: _______________________________________
   Findings at check-up: _____________________________________________________

86. Have you had a prior psychological or neuropsychological evaluation YES or NO
   Name of psychologist: ____________________________________________________
   Address; ________________________________________________________________
   Telephone: ______________________________________________________________
   Date and reason for evaluation: ___________________________________________
   Findings of evaluation: __________________________________________________

87. Have you had psychological treatment YES or NO? If “YES”
   Name of therapist: ________________________________________________________
   Address; _________________________________________________________________
   Telephone: ______________________________________________________________
   Dates of treatment and reason for evaluation: ________________________________
# REVIEW OF SYSTEMS

**Constitutional Symptoms**
- Good General Health today
- Recent Weight Change
- Fever/Chills
- Fatigue
- Fever

**Musculoskeletal**
- Joint Pain
- Joint Stiffness or Swelling
- Weakness of Muscles or Joints
- Muscle Pain or Cramps
- Back Pain
- Cold Extremities
- Difficulty Walking

**Eyes**
- Eye Disease/Injury/Blindness
- Wear Glasses/Contact Lenses
- Blurred, Dizziness or Double Vision
- Glaucoma

**Skin**
- Rash or Itching
- Change in skin color
- Change in hair or nails
- Varicose Veins
- Breast Pain or Lump
- Breast Discharge

**Ears, Nose, Mouth, Throat**
- Hearing Tones or Ringing
- Hearing Loss
- Chronic sinus problem or tinnitus
- Nose bleeds
- Mouth Sores
- Bleeding Gums
- Bad Breath or Bad Taste
- Voice Change
- Swollen neck glands

**Neurological**
- Problems with Sleep
- Frequent or Recurring Headaches or Migraines
- Light-headed or dizzy
- Convulsions or Seizures
- Numbness or tingling sensation (arms/legs-face)
- Tremors
- Paralysis
- Stroke, Meningitis, Encephalitis, Seizure
- Head Injury
- Frequent Falls
- Chronic Fatigue

**Cardiovascular**
- Heart Trouble
- Chest pain or Angina Pectoris
- Palpitations
- Shortness of Breath w/ walking/lying flat
- Swelling of Feet or Ankles

**Psychiatric**
- Nervousness
- Depression, Nervous Breakdown
- Insomnia
- Word-Finding Difficulty
- Problems with Attention/Concentration
- Memory Loss or Confusion

**Respiratory**
- Chronic or Frequent Coughs
- Spitting up Blood
- Shortness of Breath
- Asthma or Wheezing

**Gastrointestinal**
- Loss of Appetite
- Change in Bowel Movements
- Nausea or Vomiting
- Reflux disease
- Constipation
- Bleeding or Blood in Stool
- Abnormal Pain or Heartburn
- Peptic Ulcer (stomach or duodenal)

**Genitourinary**
- Incontinence
- Kidney Stones
- Sexual Difficulties
- Pregnancy Difficulties
- Irregular Periods

**Endocrine**
- Heat or Cold Intolerance
- Skin Becoming Drier
- Change in Hat or Glove Size
- Glandular or Hormonal Problems
- Thyroid Disease
- Diabetes
- Excessive Thirst or Urination

**Hematological/Lymphatic**
- Slow to Heal Cuts
- Anemia
- Phlebitis
- Blood Transfusion
- Enlarged Glands
- Tendency to Bleed or Bruise Easily

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*Thank you for filling out this lengthy form*