FirstChoice Primary Care
HEALTH CARE YOU CAN TRUST
9841 Washingtonian Blvd, Suite 200
Gaithersburg, Maryland 20878
Office: (240) 720-7797 Fax: (833) 941-2314

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to

make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many

conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Instructions for Notice

- This notice was published and becomes effective on/or before May 24, 2022
- If you have any questions regarding our privacy practices please contact Airelle Rucker-Smith DNP, CRNP, Medical Director, office: (240) 720-7797, email: contactus@firstchoiceprimary.com
- Our practice is able to provide you access to your medical records through the Athena Patient Portal. You may register for portal access on our website www.firstchoiceprimary.com or by calling the office at (240) 720-7797.
- FirstChoice Primary Care has chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and

Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

My signature below is an acknowledgement that I received a copy of this notice or have been advised that it is available on the practice's website at www.firstchoiceprimary.com

_____	_____
Patients Name (Print)	Date of Birth
_____	_____
Patient's Signature	Date
_____	_____
Guardian's Signature (if patient is a minor)	Date

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NOTICE OF PRIVACY PRACTICES CRISP ACKNOWLEDGMENT

FirstChoice Primary Care has chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. We encourage you to read our Notice of Privacy Practices at www.firstchoiceprimary.com and find out more about CRISP medical record sharing policies at www.crisphealth.org.

You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

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_____	_____
Patients Name (Print)	Date of Birth
_____	_____
Patients Signature	Date
_____	_____
Guardian's Signature (if patient is a minor)	Date

FirstChoice Primary Care

HEALTH CARE YOU CAN TRUST

Name:
DOB:

Consent to Treat Form

1. I _____ (patient name) voluntarily give permission for **FirstChoice Primary Care** to give me medical treatment.

2. I allow **FirstChoice Primary Care** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **FirstChoice Primary Care** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have a right to be involved in my treatment plan.
   - I have the right to discuss all medical treatments with my clinician.
   - I have the right to have all questions answered to my/our satisfaction.

4. I understand:
   - I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).
   - I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.
   - I am legally competent and have the authority to provide consent for treatment.

_____ _____
Patient's signature Date

_____ _____
Parent/ legal guardian signature Date
(for children under 18)

_____ _____
Print name Date

* If patient is a minor, signature may be required, depending on state law.

FirstChoice Primary Care

HEALTH CARE YOU CAN TRUST

Name:
DOB:

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner.

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Video is often used so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider cannot examine you as closely during a telehealth visit like they can at an office visit. There may be things your provider is not able to adequately examine. Therefore, it is important to maintain your follow up appointments and communicate changes promptly to your provider.
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- Anytime you use technology there is a very small chance that someone could attempt to hear or see your telehealth visit. We abide by HIPPA laws and take every precaution possible to minimize this.

How do I prepare for my telehealth visit?

- After you schedule your appointment, you will receive a link via text and/or email.
- Prior to your appointment, please obtain and write down your vital signs (heart rate, blood pressure, temperate and oxygen saturation).
- The provider will review your vital signs during the visit
- If you cannot obtain the vital signs before your appointment, do not worry we will continue with the visit.

What if I want an office visit, not a telehealth visit?

For now, almost all visits are by telehealth. You cannot schedule an office visit now, until our physical location is open:

You must wait until the office opens for all other appointments. We expect to open this Summer/Fall 2022.

What if I try telehealth and don’t like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit. But until the office opens for all appointments, you will get an office visit only for one of the reasons listed above.

- If you decide you do not want to use telehealth again:
    - call 240-720-7797 and say you want to stop, **OR**
    - sign into your patient portal and send the office a message.
    - It will be as if you never signed this form.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

No. Only sign this document if you want to use telehealth.

Do not sign this form until you start your first telehealth visit.
Your provider will discuss it with you.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You want a telehealth visit.

If you sign this document, we will give you a copy.

Your name (please print)	Date
Your signature	Date
Parent/ legal guardian signature	Date

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Financial Agreement

Patient Name: _____ DOB: _____ Date: _____

Dear Patient,

We value our relationship with you. This form outlines the financial aspects of our services. Some of the information outlined within this policy include our obligations to comply with insurance, Federal, Privacy and Fair Collections Acts. Your financial responsibilities related to your healthcare are included as well.

Red Flags Rule
The Federal Trade Commission developed a set of rules to protect consumers against identity theft. In order to protect your identity we require a photo ID & Insurance Cards at each visit. We have internal protocols to assist us with protecting your identity and financial information.

HIPAA
In compliance with HIPAA regulations, we are unable to discuss details of services rendered or to produce an itemized bill for any parties that are not the patient, unless authorized in writing by the patient.

Medical Fees and Payments
Fees are based on the complexity of your visit or procedure. Unmet Deductibles, co-payments and outstanding balances are due at the time services are rendered. We accept Visa, Master Card, cash, personal checks and money orders. We accept secured payments over the phone at 240-720-7797.

Change of Insurance
It is your responsibility to provide our office with any insurance changes. Claims denied due to "untimely billing" will be the patient's responsibility, if we were not initially provided with the correct billing information, which resulted in late submission.

Form Completion & Medical Record Copying Fees
We charge $25-50 for the completion of forms including but not limited to Disability documents. We also adhere to Maryland State Medical Records copying fees which are $0.76 per page, not to exceed $75. Records may be subject to a processing fee of $22.88.

Missed or Cancelled Appointments
As a courtesy to other patients who need to be seen, if you need to cancel your appointment please call at least 24 hours in advance. Excessive no shows may result in dismissal from the practice.

Returned Check Charge
Non-Sufficient Funds (NSF) are subject to a $25 Fee (in addition to fees from your bank). Cash payments will be expected after more than one NSF fee.

Self- Pay Patients
Our practice will give you an estimate of what will be due. Sometimes it is medically necessary to add services. When this occurs, our Providers will notify you. Payment for all services are due at your visit. There might be instances in which you are billed for the services added to your visit.

Discounts for Self-Pay Patients
For patients without insurance, we might be able to offer a prompt pay discount from our standard (usual and customary) fee schedule. This discount applies only to patients without insurance or those who inform us in writing that they wish that we not bill their insurance for services provided in our office. This discount is only available if the discounted amount is paid in full at the time of the office visit or diagnostic test. Please note that for those patients who take advantage of our prompt pay discount, your account will reflect our full standard charge for the actual service(s) provided, and the discount will be applied to those services to reflect the discounted amount paid at time of service.

Payment Plans
In some instances, our office will work with you to develop a plan to assist you in paying outstanding balances with our practice. Contact our billing department at 240-720-7797.

Minor Patients
Parent(s) or guardian(s) accompanying a minor for medical services are responsible for providing insurance information and payment of the services rendered to the minor child.

Coordination of Benefits
Sometime you may have more than one insurance company assisting you with your medical expenses. Your secondary or tertiary insurance will require that you inform us of the correct billing sequence.

Non-Payment of Outstanding Accounts
We make many efforts to assist our patients with managing their medical bills. Please contact us if you are having difficulty with payments. Accounts that are not paid in a reasonable amount of time may be sent to an external collection agency. Should the account be referred to a collection agency or an attorney for past due amounts, the patient shall incur attorney's fees, court costs and all applicable collections expenses.

Referrals
Some insurance carriers may require you to obtain a written referral from your primary care provider for specialty services. We will only perform services and file claims for authorized services based on your insurance carrier's guidelines. Payment for unauthorized services will be due at the time service is rendered.

Assignment of Insurance Benefits and Third Party Claims
By signing this document, you authorize benefits from your insurance company to be made on your behalf to FirstChoice Primary Care LLC for services furnished to you by our providers. You also authorize release of your medical information necessary to process insurance claims on your behalf. If you do not agree with this then our office will be unable to submit insurance claims on your behalf and payment in full will be expected prior to services being provided.

Financial Attestation
I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of any services provided to me. Payment is due at the time services are rendered which includes co-payments, deductibles, and co-insurance with my carrier.

I have read this entire document and agree to the terms. I will notify the office of any changes in my personal and billing information.

_____	_____	_____
Name (Print)	Signature	Date
_____	_____	_____
Name of Parent/legal guardian (Print)	Signature	Date

Patient Name	Date of Birth	Patient ID # (Office Use)

Today's Date:

Patient Health History Forms

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Medical History

Check all diseases and conditions that apply.

- ☐ Abnormal bleeding/bleeding disorders
- ☐ Acid Reflux (GERD)
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Back Problems
- ☐ Blood clotting disorders/Deep Vein Thrombosis (DVT)
- ☐ Blood Disorders
- ☐ Blood Transfusion
- ☐ COPD
- ☐ Cancer
- ☐ Congestive Heart Failure (CHF)
- ☐ Constipation
- ☐ Heart disease/problems
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ History of sexually transmitted infections
- ☐ HIV/AIDS
- ☐ History of abuse/domestic violence
- ☐ Hospitalizations
- ☐ Hypertension (High blood pressure)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Kidney Stones
- ☐ Kidney or Bladder Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Illness
- ☐ Muscle, Joint, or Bone Problems
- ☐ Nervous System Disorder
- ☐ Obesity
- ☐ Parkinson's Disease
- ☐ Polyps
- ☐ Previous complications with anesthesia

- ☐ Difficulty Swallowing
- ☐ Ear or Hearing Problems
- ☐ Edema
- ☐ GI Problems
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack (MI)
- ☐ Heart Problems
- ☐ Hematologic disorders
- ☐ High Cholesterol
- ☐ Lung problems
- ☐ Pulmonary Embolism
- ☐ Seizures/Epilepsy
- ☐ Skin Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Urinary Problems
- ☐ Vision or Eye Problems
- ☐ Other

Immunizations

Check all vaccinations you have received.

- ☐ BCG — Date received (approx.) ____ / _____
- ☐ COVID-19 (SARS-COV-2) vaccine — Date received (approx.) ____ / _____
- ☐ Hep B Vaccine — Date received (approx.) ____ / _____
- ☐ HPV Vaccine — Date received (approx.) ____ / _____
- ☐ Influenza (Flu) vaccine — Date received (approx.) ____ / _____
- ☐ Pneumococcal (pneumonia) Vaccine — Date received (approx.) ____ / _____
- ☐ Shingles (Herpes zoster) vaccine — Date received (approx.) ____ / _____
- ☐ Tetanus-diphtheria vaccine — Date received (approx.) ____ / _____
- ☐ Tetanus-diphtheria-pertussis (Tdap) vaccine — Date received (approx.) ____ / _____

Social History

1. Have you traveled Internationally within the last 30days? (Circle one)

   Yes No

2. Have you been to an area known to be high risk for COVID-19? (Circle one)

Yes No

3. What is your occupation? _____

4. What is your relationship status? (Circle one)

Widowed	Divorced	Other	Domestic partner
Separated	Unknown	Single	Married

5. What is the highest grade or level of school you have completed or the highest degree you have received? (Circle one)

Doctoral degree (example:PhD, EdD)	High school graduate	Professional school degree (example: MD, DDS, DVM, JD)	9th grade
Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)	1st grade	4th grade	Associate degree: academic program
8th grade	6th grade	Never attended/kindergarten only	Don't know
Refused	GED or equivalent	7th grade	12th grade, no diploma
3rd grade	10th grade	Associate degree: occupational, technical, or vocational program	Bachelor's degree (e.g., BA, AB, BS)
11th grade	2nd grade	5th grade	Some college, no degree

6. How many times per week do you exercise? (Circle one)

1-2 times per week	5-7 times per week	3-4 times per week

7. Are you a caregiver? (Circle one)

Yes No

8. Are you able to care for yourself? (Circle one)

Yes No

9. Are you sexually active? (Circle one)

Yes No

10. Do you want to talk about contraception or pregnancy prevention during your visit today? (Circle one)

No - I am hoping to become pregnant in the near future	No - This question does not apply to me/I prefer not to answer	No - I do not want to talk about contraception today because I am here for something else	Yes
No - I am already using contraception	No - I am unsure or don't want to use contraception		

11. Do you have concerns about meeting basic needs (food, housing, heat, etc)? (Circle one)

Yes No

12. Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)? (Circle one)

To some extent | Only a little | Not at all | Very much

Rather much

13. Do you have an advanced directive? (Circle one)

Yes No

14. Do you have a medical power of attorney? (Circle one)

Yes No

15. Do you or have you ever smoked tobacco? (Circle one)

Unknown if ever smoked | Not indicated | Former smoker | Current some days smoker

Never smoker | Smoker - current status unknown | Not tolerated | Current every day smoker

Patient refused

16. Do you or have you ever used any other forms of tobacco or nicotine (e-cigarettes, vape, chew)? (Circle one)

Yes No

17. How many years have you smoked tobacco? _____

18. When did you quit smoking? (Circle one)

1-5 years since last cigarette | 11-15 years since last cigarette | 6-10 years since last cigarette | 16+ years since last cigarette

19. Do you use any illicit or recreational drugs? (Circle one)

Yes No

20. How many times per week do you consume alcohol? (Circle one)

1-2 times per week | 5-7 times per week | 3-4 times per week

21. Do you use sunscreen routinely? (Circle one)

Yes No

22. Do you use your seat belt or car seat routinely? (Circle one)

Yes No

23. Do you wear a helmet when biking? (Circle one)

Yes No

24. Are there any guns present in your home? (Circle one)

Yes No

Medications

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

Medication	Dosage	Frequency

Allergies

List all known allergies.

Allergy	Reaction(s)	Date of First Reaction (approx.)	Not Current
		___ / ___	
		___ / ___	
		___ / ___	
		___ / ___	

Family History

Check all diseases and conditions that apply.

- ☐ Alcohol abuse — Family member(s): _____
- ☐ Alzheimer's disease — Family member(s): _____
- ☐ Anemia — Family member(s): _____
- ☐ Anxiety disorder — Family member(s): _____
- ☐ Arthritis — Family member(s): _____
- ☐ Asthma — Family member(s): _____
- ☐ Stroke — Family member(s): _____

- ☐ Chronic obstructive lung disease — Family member(s): _____
- ☐ Dementia — Family member(s): _____
- ☐ Depression — Family member(s): _____
- ☐ Diabetes mellitus — Family member(s): _____
- ☐ Headache/Migraines — Family member(s): _____
- ☐ Heart problems — Family member(s): _____
- ☐ High risk pregnancy — Family member(s): _____
- ☐ High cholesterol — Family member(s): _____
- ☐ Hypertension (High blood pressure) — Family member(s): _____
- ☐ Kidney problems — Family member(s): _____
- ☐ Mental illness — Family member(s): _____
- ☐ Multiple sclerosis — Family member(s): _____
- ☐ Heart attack (Myocardial infarction) — Family member(s): _____
- ☐ Seizure disorder — Family member(s): _____
- ☐ Substance abuse — Family member(s): _____
- ☐ Nervous system problems — Family member(s): _____
- ☐ Liver problems — Family member(s): _____
- ☐ Lung problems — Family member(s): _____
- ☐ thyroid gland problems — Family member(s): _____
- ☐ Endometrial Cancer — Family member(s): _____
- ☐ Uterine Cancer — Family member(s): _____
- ☐ Breast Cancer — Family member(s): _____
- ☐ Cervical Cancer — Family member(s): _____
- ☐ Colon Cancer — Family member(s): _____
- ☐ Lung Cancer — Family member(s): _____

- [ ] Ovarian Cancer — Family member(s): _____
- [ ] Cancer — Family member(s): _____

Surgical History

Check all surgeries that apply.

- [ ] Back Surgery
- [ ] Bariatric Surgery
- [ ] Cancer Surgery
- [ ] Cardiac Surgery
- [ ] Cardiac Pacemaker
- [ ] Coronary Artery Bypass (CABG)
- [ ] ENT Surgery
- [ ] Eye Surgery
- [ ] Gallbladder Surgery
- [ ] Gastric Bypass
- [ ] Gastrointestinal Surgery
- [ ] Genitourinary Surgery
- [ ] Knee Surgery
- [ ] Orthopedic Surgery
- [ ] Prostate Surgery
- [ ] Splenectomy
- [ ] Stent Placement
- [ ] Thyroid Surgery
- [ ] Tonsillectomy
- [ ] Other