12596 W. Bayaud Ave, suite 205, Lakewood CO 80228 I (p): 303-945-4790 I (f) 720-645-1959 I regeneration@mhrapt.com

Name:_____Date of Birth:_____Sex: ___Male ___Female

Address:_____(City, State, Zip)_____

Home Phone:_____Cell Phone:_____Work:_____

Best Way to Contact You: ___Home ___Cell ___Work

Marital Status: ___Single ___Married ___Widowed ___Divorced

Emergency Contact Name/Phone:_____Relationship:_____

Employment Status: ___Employed ___Part-time Student ___Full-time Student ___Other_____

Employer:_____Occupation:_____

Address:_____(City, State, Zip):_____

Insurance Name:_____Insurance Phone:_____

ID#:_____Group Name/Number:_____

Does your insurance require you to have a referral/authorization to see a specialist? ___YES ___NO

Do you have a valid referral on file to see Dr. Robert Brown or Shannon Bock, PA-C? ___YES ___NO

Was your illness caused by an injury on the job or motor vehicle accident: ___YES ___NO
(If you marked **"YES"** please see the front desk for additional paperwork)

Referring Providers Name:_____Phone:_____

Address:_____(City, State, Zip):_____

Consent to Treatment/Financial Responsibility and Assignment of Benefits:

I voluntarily consent to receive medical and health care services provided by Mile High Regenerative and Pain Therapy that may include examination, diagnostic procedures, and treatment.
I hereby assign, transfer, and set over to Mile High Regenerative and Pain Therapy all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking the said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.
I certify that I have read this form and understand its contents

Patient or Other Legally Authorized Person:_____Date:_____

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Patient Name:_____ **DOB:**_____

HIPAA Privacy Rule of Patient Authorization Agreement
Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who may contribute to my health care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested
- I have the right to object to the use of my health information for directory purposes
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Patient Signature (Or Patient Representative):_____Date:_____

12596 W. Bayaud Ave, suite 205, Lakewood CO 80228 I (p): 303-945-4790 I (f) 720-645-1959 I regeneration@mhrapt.com

Patient Name:_____ **DOB:**_____

OFFICE POLICIES

Our commitment is to provide the very best pain management care to our patients. As Such, it is important for us to provide you with our office policies and information. In meeting this commitment, we recognize the need for a definite understanding and agreement concerning your health care and the associated office policies in providing your medical care. Your clear understanding of our office policies is important to our professional relationship with you. Please contract our office manage regarding any questions about our policies. For any questions regarding your insurance coverage and responsibilities please contact your insurance company

Please initial each section below

_____**PROFESSIONAL FEES:** Our fees for medical services are comparable to other similarly trained medical providers in the community. Our fees reflect the provider's time dedicated to your care including review of any prior medical records diagnostic testing as well as coordinating your care with your primary and/or referring physician.

_____**LATE/NO SHOW POLICY:** Please be advised that you are expected to arrive 30 minutes prior to your appointment. This will allow for a proper check in process.

If you arrive later than 10 minutes after your designated check in time, you may be asked to reschedule or be seen as a walk in if there is a provider available.

If you are unable to make your appointment, please call our office at 303-945-4790 and reschedule so that other patients can be accommodated. **If you do not show up for your appointment and do not call to cancel at least 24 hours prior to your appointment, you will be considered a no-show, and you will be charged a $50.00 for an office visit and $150.00 for a procedure.** Once you have acquired two no-shows or late appointments, you may be asked to find a new provider.

_____**COPAYS/INSURANCE BALANCES/SELF PAY:** Your co-payment/deductible/coinsurance is a contractual agreement you and your insurance company that you are expected to make payment at the time of service.

If you have an un-met deductible, you may be required to pay that amount at the time of your visit or procedure. Any overages paid will be refunded to you after review of your account and will be paid via check.

Any unpaid balances over 90 days may be subject to be sent to a collection agency and you may be subject to being discharged from our practice

A 50.00 charge will be applied to your balance for each check that is returned by our bank

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Patient Name:_____ **DOB:**_____

Please initial each section below

_____**INSURANCE PAYMENTS:** We participate in assignment of payments with specific insurance plans in the Colorado area. When the correct insurance information is provided (We must take a copy of your insurance card at the time of your visit. If you are unable to provide us a copy of your insurance card, we may have to reschedule your appointment), we will submit your claim(s) as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. It is your responsibility to verify and now your insurance benefits, including out of requirements and if our office is in network or out of network with your insurance and if you are required to have a referral to see a specialist(s).

_____**FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:** I understand that I am financially responsible and agree to pay all of the charges that are not covered by my insurance or any other third-party payer. I authorize payment directly to Mile Regenerative and Pain Therapy for all benefits otherwise payable to me.

_____**ADDITIONAL FEES:** Mile High Regenerative and Pain Therapy reserves the right to charge additional fees that are not outlined above which incorporates up to and including any services that are above and beyond the "normal" coordination of care for patients.

_____**LABORATORY TESTING:** Your provider may require you to have blood or urine testing preformed at an outside laboratory that is within network of your insurance. You will receive a separate bill from the laboratory for which you will be responsible for. Your medical insurance frequently pays for all or a portion of these charges. If you do not have insurance, there may discounts for some test. Please contact the laboratory to discuss any questions or concerns you may have.

_____**URINE TOXICOLOGY (DRUG) SCREENING TESTS AND SEND OUT TESTS:** Mile High Regenerative and Pain Therapy has a strict policy regarding prescribing controlled substances to our patients. This is to protect our patients who are using controlled substance as well as to protect the integrity of Mile High Regenerative and Pain Therapy.

All patients on any or requesting a controlled substance will receive an initial urine toxicology screening at an outside lab. This could be a 6-panel or 10-panel test, depending on the medication being requested.

The frequency of the drug screenings is at the discretion of the treating provider.

A patient's insurance may or may not pay for urine drug tests and if the insurance does not pay, it is the patient's responsibility to pay for the urine drug screen at the time of service.

12596 W. Bayaud Ave, suite 205, Lakewood CO 80228 I (p): 303-945-4790 I (f) 720-645-1959 I regeneration@mhrapt.com

Patient Name:_____ **DOB:**_____

Please initial each section below

_____**COLORADO PRSCRIPTION DRG MONITORING PROGRAM:** Mile High Regenerative and Pain Therapy utilizes the Colorado Prescription Drug Monitoring Program (PDMP) to monitor controlled substance use by our patients.

- The information in the PDMP relates only to controlled substances dispensed to a patient
- "Controlled substances" are drugs that have some potential for abuse or dependence (such as Opioid pain medications, prescription sleeping pills, ADD/ADHD medications, testosterone).
- It is **ILLEGAL** to get a prescription for a controlled substance through fraud or deceit
- The patient's information in the PDMP is part of the medical record. It can be viewed by those who treat you and consider prescribing you a controlled drug, or by the pharmacist dispensing a controlled drug to you.
- You may request your PDMP information through the state pharmacy board
- Law enforcement officials may review your information with a court order or subpoena as part of an investigation

_____**PRESCRIPTION REFILL(S):** Please contact your pharmacy and ask them to send us a request via fax. It is our policy that all prescription refills requests are processed within 48-72 hours from the time of the request. Please understand that prescription refills, especially for controlled substances, may require prior authorization and this could take an additional amount of time to process. No refill requests will be processed on Friday, Saturday, Sunday and major holidays. Please make sure that you give our office ample time to process your request for we ***DO NOT*** write gap prescripts.

_____**FORMS:** You may schedule an appointment with the provider to have disability forms, attending physician statements and other supplemental insurance forms completed. A fee will be assessed and due at the time of the forms being completed by your provider. Please contact our office manager for the fee.

_____**RELEASE OF INFORMATION:** I authorize Mile High Regenerative and Pain Therapy to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for this treatment, and for quality management, utilization, review, transfer and follow-up purposes. I understand that a copy of this agreement may be used with the same effectiveness as an original.

_____**CONSENT AND DISCLOSURE:** I voluntarily consent to treatment for myself and/or my dependents

I fully understand all of the above policies and agree to these terms and conditions by signing below.

Patient or (Patient Representative):_____Date:_____

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Patient Name:_____ **DOB:**_____

Confidential Channel Communication Request

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request and will try to accommodate all reasonable requests.

I, _____ (*print name*) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

Please select all that apply.

❑ **Phone.** I want you to contact me by telephone at _____

❑ Do ❑ Do not leave messages on my answering machine.

❑ Do ❑ Do not leave messages with any other person.

❑ Do ❑ Do not text messages

❑ **Mail.** I want you to mail my information to the following address:_____

❑ **Fax.** I want you to contact me at the following fax number: _____

❑ **Additional Contacts.** Please list the names of other parties (family members, friends, attorney, etc.) that you authorize Mile Hile Regenerative and Pain Therapy to discuss your treatment/health with**:**

Name:_____ **Relationship:**_____ **Ph:**_____

Name:_____ **Relationship:**_____ **Ph:**_____

Emergency Contact: _____**Ph:**_____

❑ **Other requests for confidential communications** (specify):_____

Patient Signature: _____ Date_____

Print Name: _____

If not signed by the patient (or plan member), please indicate your relationship:

[ ] Parent or guardian of minor patient

[ ] Guardian or conservator of an incompetent patient

[ ] Beneficiary or personal representative of deceased patient

[ ] Other (specify) _____

12596 W. Bayaud Ave, suite 205, Lakewood CO 80228 I (p): 303-945-4790 I (f) 720-645-1959 I regeneration@mhrapt.com

Patient Name:_____ **DOB:**_____

CARD ON FILE AGREEMENT

I _____, agree to allow Mile High Regenerative and Pain Therapy to charge my credit card ending in _____ for any amount not covered by insurance (up to the maximum charge amount), for all services provided by Mile High Regenerative and Pain Therapy to the patient on or after the effective date and before the expiration date. I acknowledge that:

- My credit card will be charged upon review of the final explanation of benefits from each applicable insurance company for services provided while this agreement is in effect.
- Once a total of $ 4,000.00 has been charged to my credit card under this agreement, Mile High Regenerative and Pain Therapy will bill me directly for any amounts not covered by insurance.
- My credit card will be stored in a secure manner with Mile High Regenerative and Pain Therapy.
- I will receive receipts detailing the amount charged
- I may cancel this agreement at any time by contacting Mile High Regenerative and Pain Therapy; any unpaid amounts relating to services provided while this agreement is in effect that are not covered by insurance will then be billed to me directly.
- This agreement will be effective for 1 year unless written notice is received.
-

Name on Card:_____CC Number:_____

Expiration:_____ CVV:_____Zip Code associated with the card:_____

Address to mail Receipt:_____

Printed Name:_____

Signature:_____Date:_____

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MHRAPT CONTROLLED SUBSTANCE AGREEMENT

Patient Name:_____DOB:_____

I authorize MHRAPT to administer treatment and medication that are deemed necessary and advisable in the treatment and diagnosis of my condition(s). I understand that I may receive narcotic pain medication or other controlled substance medications, because alternative treatments and medications have not adequately controlled my pain. It is unlikely tht any medication will completely take away my pain, but narcotic pain medication maybe given to me to help in controlling my pain, if I follow the terms of this agreement

I understand that the possible complications of narcotic therapy include, but are not limited to chemical dependence (physiologic need for medication, withdrawal symptoms if medication use is abruptly reduced), tolerance (failure of same dosage to provide same effect), addiction (aberrant behaviors related to medication use), constipation, difficulty with urination, fatigue, drowsiness, nausea, vomiting, itching, stomach cramps, loss of appetite, confusion, perspiration, flushing, dizziness, allergic reaction, decreased reaction time, depressed respiration, and reduced sexual function. Additional medication may help with some of these side effects, but at times the narcotics will need to be reduced or discontinued. Overdose of these medications may cause injury or even death. I may not be able to safely operate machinery or drive while on this medication, especially while it is being started or adjusted. I am responsible for making honest, careful assessments about my alertness, response time, attention, and physical coordination while taking this medication to minimize risk or injury to myself or to others.

I understand that the main treatment goal is to improve my ability to function and/or work and such medications are not the only option available to me for treatment. In addition to other treatment options discussed with our providers, I also understand that adherence to a healthier lifestyle can contribute to decreased pain and improved function. In the consideration of that outcome, I agree to help myself by following better health habits specifically involving exercise, weight control, and the cessation of tobacco, alcohol and illicit/illegal substance use. Also, risk assessment, psychological evaluation and/or treatment may be required as a condition of this agreement and continued prescribing of controlled substances at the discretion of my provider. My care will be reviewed regularly, and ongoing prescribing of these medications may be contingent on clinical evidence of maintained or improved functioning.

If controlled medications are prescribed to me as part of my treatment plan, I agree to the following conditions:

PLEASE INITIAL EACH LINE ITEM

_____I will take controlled substance medications ONLY as prescribed by my physician/provider. I will comply with the prescribed dosing and frequency of recommended use and will not alter the way I take it without consulting a MHRAPT provider and will inform my provider about all other medications and treatments that I am receiving.

_____I am responsible for my controlled substance medication. If the prescription or medication is lost, misplaced, stolen or I use it up sooner than prescribed, I understand that **it will not be replaced**. I will not share, sell or trade my medication. I will keep it in a safe and secure location and out of reach of children.

_____I will not request nor accept controlled substance medication from any other physician/provider while I am receiving such medication from MHRAPT. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital or discussed and coordinated with my MHRAPT provider and any other provider I see.

_____ MHRAPT will not prescribe or refill narcotic medications without an appointment. I realize an office or telemedicine visit is required, and it is my responsibility to schedule that visit well in advance of running out of medication. They will not be refilled at procedure appointments. I understand refills will not be made if I run out early, and medication refills are not a medical emergency. Refills will be allowed to be dispensed by pharmacy on the 30th day of your current 30-day supply, unless there are special circumstances discussed with the provider. Refills will be contingent upon compliance with other treatment recommendations, including regular attendance to follow-up visits. Refills will require visits every 1 to 3 months, as determined by provider.

12596 W. Bayaud Ave, suite 205, Lakewood CO 80228 I (p): 303-945-4790 I (f) 720-645-1959 I regeneration@mhrapt.com

PLEASE INITIAL EACH LINE ITEM

_____I will be required to submit to random drug screening during my treatment, which may include urine, saliva and/or blood samples for monitoring compliance of my controlled substance use. I agree to pay all costs associated with drug screens, medications, physician visits and my narcotic treatment program.

_____I agree not to use any federally mandated illegal drugs or consume alcohol, while I am prescribed these types of drugs. The use of Kratom is highly discouraged due to risk of serious side effects and safety concerns by the FDA.

_____I understand there are other commonly used medications, such as benzodiazepines (diazepam, lorazepam etc), that have a black box warning regarding their use with opioids due to risk of CNS, respiratory depression or psychomotor impairment. Due to this risk, MHRAPT will generally not manage these medications, and will require a letter of medical necessity from a provider who may decide that use of such medication is indicated and manages those for you. Soma (carisoprodol) is similar type of medication and due to adverse additive effects, will not be managed by MHRAPT.

_____I understand MHRAPT follows state guidelines regarding maximum morphine equivalents, and pill quantities allowed. If I am not currently at those levels but am a current patient, I understand my provider will be working with me on a gradual taper of dose., and/or looking at other treatment options that have not yet been exhausted. Additionally, MHRAPT will no longer manage 30mg immediate release oxycodone.

_____I will be required to keep a current, filled prescription of naloxone for accidental/unintentional overdose if I am on greater than 50 MME, have conditions that may affect my oxygen levels, or am prescribed other medications that could increase CNS or respiratory depression.

_____I understand I may be called for random pill counts to ensure compliance or for purposes of surrendering medications when a change in prescription is made.

_____I understand my provider may choose to wean me completely off all narcotics to better control tolerance/increase effectiveness, or if it is felt they are no longer the best treatment option. I understand should I experience withdrawal; my provider may prescribe non-controlled medications to help with those symptoms.

_____I understand that if I or my provider feel I have an opioid use disorder I have options of medication assisted treatment that can be offered, either by this office or with referral to another provider for options such Suboxone, counseling, in or outpatient treatment facilities.

If I violate any of the above conditions (or if compliance is in question based on urine testing /other information), it may result in discontinuation of controlled substance prescribing at the discretion of my provider and could result in discharge from the practice; and I may be reported to other treating physicians/medical facilities and/or local, state or federal authorities. Furthermore, I waive any applicable privilege or right of privacy/confidentiality with respect to my being prescribed controlled substances and authorize my physician, pharmacy, and insurer to fully cooperate with law enforcement authorities in investigating any potential misuse of these medications.

I will use only _____ pharmacy for these medications and I authorize you to supply them with a copy of this contract and will inform you if that should change.

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Faxed to pharmacy on _____ by _____

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Patient Name:_____DOB:_____

Please list all medications you are currently taking including any blood thinners and who manages your medications

Medication	Dose/Frequency	Who manages/prescribes medication

Please list any drug allergies you may have including medications, latex, tape, Iodine, etc.

Medication	Reaction

Previous Diagnostic Exams

	Which Body part	Date of exam	Facility Imagine was done at
MRI			
CT SCAN			
X-RAY			

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Patient Name:_____**DOB:**_____

Previous Injections

Date of Injection	Area Treated	Percentage of relief	Performed by

PAST MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

MUSCULOSKELETAL:
Arthritis
Back pain
Bursitis
Carpal Tunnel Syndrome
Chronic Joint Pain
Chronic Neck Pain
Costochondritis
Degeneratice disc disorder
Fibromyalgia
Muscular dystrophy
Osteoarthritis
Osteoporosis
Raynaud's phenomenon
Reflex Sympathetic dystrophy
Spinal Stenosis
Thoracic outlet syndrome
Trigger Finger
Vertebral Compression Fracture
Other:_____

Gastroenterology:
Appendicitis
Gallbladder Disease
Gastroesophageal Reflux
Hepatitis
Pancreatitis
Ulcerative Colitis
Crohn's Disease
Other:_____

NEUROLOGY:
Alzheimer's Disease
Bell's Palsy
Epilepsy
Head Injury
Headache
Multiple Sclerosis
Neuropathy
Parkinson's Disease
Stroke
Trigeminal neuralgia

RESPIRATORY
Asthma
Chronic Bronchitis
COPD
Cystic Fibrosis
Emphysema
Pneumonia
Sleep Apnea
Other:_____

Genitourinary:
Renal Failure

Endocrine:
Diabetes
Hyperthyriodism
Hypothyroidism
Other:_____

PSYCHIATRY:
Alcoholism
Anxiety
Bipolar Disorder
Depression
Drug Abuse
PTSD
Other:_____

RHEUMATOLOGY:
Gout
Lupus
Rheumatoid Arthritis
Other:_____

Cardiovascular:
Angina
Atrial Fibrillation
Congestive heart failure
Coronary artery disease
Hypercholesterolemia
Hypertension
Myocardial infarction
Other:_____

Infectious Disease:
AIDS
Lyme Disease
Hepatitis
Other:_____

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Patient Name:_____**DOB:**_____

SURGICAL HISTORY (pls list all surgeries and dates)

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Are you Adopted: _____YES _____NO

	Cancer	Hypertension	Renal Disease	Thyroid	Asthma	Diabetes	Heart Disease	Arthritis	Other
Grandmother									
Grandfather									
Mother									
Father									
Sibling									
Sibling									

SOCIAL HISTORY

Tobacco Use
Former Smoker or Tobacco user
Never Smoker or Tobacco user
Social Smoker or Tobacco user
# of Cigarettes per day_____

Alcohol Use
Former Drinker
Never Alcohol user
Social Drinker
# of Drinks per week_____

Recreational Drug
Former User
Never Drug user
Social Drug user
Drug_____

MILE HIGH REGENERATIVE AND PAIN THERAPY

12596 W. Bayaud Ave, suite 205, Lakewood CO 80228 I (p): 303-945-4790 I (f) 720-645-1959 I regeneration@mhrapt.com

Patient Name:_____**DOB:**_____

In the last 14 days have you been exposed or tested for COVID-19? _____YES _____NO

When were you tested:_____
Where were you tested:_____
What were your results_____
Do you currently have COVID-19 symptoms_____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS TODAY (PLEASE CIRCLE ALL THAT APPLY)

Constitutional
Fatigue/Drenching night sweats
Fever/Chills
Unexplained weight loss/gain

Eyes
Blurry vision/double vision
Cataracts/macular degeneration
Glasses/contacts/blindness
Partial loss of vision/blind spots

Ears/Nose/Mouth/Throat
Dentures
Difficulty Swallowing
Hearing loss/ringing in ears
Prolonged nose bleeds
Voice change

Cardiovascular
Ankle Swelling/Varicosities
Calf pain with/without exercise
Chest pain with/without exertion
Heart Murmur
Dyspnea on exertion/Syncope
Irregular/rapid heart rate
Leg Pain/Cramping in legs at night

Respiratory
Asthma/Anesthetic problems
COPD/Pneumonia/Emphysema
Coughing/Coughing up blood
Hoarseness/Obstructive Sleep Apnea
Oxygen Dependent LMP_____
Shortness of breath with exertion
Shortness of breath/wheezing
Tuberculosis or exposure

Gastrointestinal
Abdominal pain
Blood in stool
Black or Tarry Stools
Loss of appetite/heartburn
Bloating/diarrhea/constipation
Nausea/Vomiting
Ulcer disease/pain after eating
Vomiting blood

Genitourinary
Impotence
Incontinence/Difficulty voiding
Kidney Stones
suprapubic/indwelling catheter
Urgency in urination

Neurological
Migraines/Headache/Vertigo
Temporary Paralysis
Tingling/Numbness
Speech Difficulties/Seizures

Musculoskeletal
Artificial knee or hip joint
Back pain/Joint pain
Degenerative/Osteoarthritis
Muscle pain/weakness/cramps
Rheumatoid arthritis

Psychiatric
Anxiety/Depression
Confusion/Memory loss
Difficulty Sleeping

Skin
New lesions/sores
Rash/Persistent itching
Unhealed lesions/sores

Heme/Lymphatic/Immune
Anemia/Low platelet count
Bleeding disorder
Easy bruising
Lymphoma/leukemia
Frequent Illnesses