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| **Adult Health History Questionnaire** | | | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Landline phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ | | | | |  |
| Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| Please describe what problem or concern brought you to our office today: | | | | |  |
| ☐To establish primary care ☐Current concern(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Special Communication Needs | | | | | |
| Language preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  |  |
| If "yes" to any of the questions below, how can we assist? | | | | | |
| Visual impairment |  | ☐Yes ☐No |  |  |  |
| Hearing impairment |  | ☐Yes ☐No |  |  |  |
| Speech impairment |  | ☐Yes ☐No |  |  |  |
| Cognitive impairment |  | ☐Yes ☐No |  |  |  |
| Sensory impairment |  | ☐Yes ☐No |  |  |  |
| Personal Health History | | |  | Previous Surgical Procedures | |
| Check if you have had any of the following: | | |  | Check if you have had any of the following: | |
| ☐Acute myocardial infarction |  | ☐Hepatic disorders |  | Procedure | Year |
| ☐Atrial fibrillation |  | ☐Renal disease |  | ☐Heart surgery |  |
| ☐Angina pectoris |  | ☐Prostate disorders |  | ☐Pacemaker |  |
| ☐Congestive heart failure |  | ☐Urinary tract infection |  | ☐Carotid artery surgery |  |
| `☐Hyperlipidemia |  | ☐Arthritis |  | ☐Vascular surgery / stent |  |
| ☐Hypertension |  | ☐Neuropathy |  | ☐Abdominal aneurysm repair |  |
| ☐Cardiac rhythm disorder |  | ☐Epilepsy and recurrent seizures |  | ☐Hysterectomy |  |
| ☐Asthma |  | ☐Headache syndromes |  | ☐Abdominal ☐Vaginal |  |
| ☐Chronic bronchitis |  | ☐Stroke syndrome |  | ☐Ovary removal |  |
| ☐Emphysema |  | ☐Aneurysm |  | ☐Right ☐Left ☐Bilateral |  |
| ☐Pneumonia |  | ☐Coagulation disorders |  | ☐Gall bladder removal |  |
| ☐Gastroesophageal reflux disease |  | ☐Cancer (please specify location) |  | ☐Appendix removal |  |
| (GERD |  |  |  | ☐Total Colectomy |  |
| ☐Irritable bowel syndrome (IBS) |  | ☐Breast disorder |  | ☐Tonsillectomy |  |
| ☐Disease of digestive system |  | ☐Anxiety disorder |  | ☐Joint replacement |  |
| ☐Peptic ulcer |  | ☐Depressive episode |  | ☐Knee ☐Right ☐Left |  |
| ☐Diabetes mellitus |  | ☐Unspecified mental |  | ☐Hip ☐Right ☐Left |  |
| ☐Osteopenia |  | disorder non-psychotic |  | ☐Spine surgery |  |
| ☐Osteoporosis |  | ☐Substance abuse |  | ☐Neck ☐Back |  |
| ☐Thyroid disorders |  | ☐Other diagnoses & conditions |  | ☐Mastectomy |  |
|  |  |  |  | ☐Right ☐Left ☐Bilateral |  |
|  |  |  |  | ☐Breast lumpectomy |  |
|  |  |  |  | ☐Hernia |  |
|  |  |  |  | ☐Prostate cancer surgery |  |
|  |  |  |  | ☐Other |  |
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| Social History | | | | | | |
| Marital status: ☐Single ☐ Married ☐ Divorced ☐Widowed ☐Life Partner | | | | |  |  |
| Live here year-round? ☐ Yes ☐ No If no, provide seasonal address: | | | | |  |  |
| Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Full time ☐Part time ☐Retired | | | | |  |  |
| Concerns: ☐Stress ☐Hazardous substances ☐Heavy lifting ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Exercise: ☐Yes ☐No If yes, how many minutes per day? \_\_\_\_\_ How many days per week? \_\_\_\_\_ | | | | | | |
| Tobacco use: ☐Never ☐ Quit (when? \_\_\_\_\_) ☐ Current smoker (packs per day? \_\_\_\_\_ number of years? \_\_\_\_\_ | | | | | | |
| Alcohol use: ☐Yes ☐No If yes, how many per: day \_\_\_\_\_ week \_\_\_\_\_ ☐Social drinker | | | | | | |
| Caffeine use: ☐Yes ☐No If yes, how many cups per day? \_\_\_\_\_ | | | | |  |  |
| Illicit drug use (including cocaine, steroids, etc.): ☐Never ☐Past ☐Current ☐Marijuana by prescription | | | | | | |
| Describe drug, frequency, purpose: | | |  |  |  |  |
|  |  |  |  |  |  |  |
| Current Health Concerns | | | | | | |
| Please check problems or conditions that you are CURRENTLY experiencing: | | | | |  |  |
| ☐Chest pain/discomfort |  | ☐Rectal bleeding |  | ☐Eye pain |  | ☐Pain in testicles |
| ☐Shortness of breath |  | ☐Black/tarry stools |  | ☐Loss of vision |  | ☐Loss of libido |
| ☐Wheezing |  | ☐Hemorrhoids |  | ☐Double vision |  | ☐Impotence |
| ☐Cough |  | ☐Diarrhea |  | ☐Memory lapses/loss |  | ☐Breast pain |
| ☐Coughing up blood |  | ☐Constipation |  | (forgetfulness) |  | ☐Breast discharge |
| ☐Sore throat |  | ☐Weight loss (\_\_\_\_ lbs) |  | ☐Ringing in ears |  | ☐Other (describe below) |
| ☐Nasal congestion |  | ☐Weight gain (\_\_\_\_ lbs) |  | ☐Pain in ears |  |  |
| ☐Irregular heartbeat |  | ☐Loss of appetite |  | ☐Nose bleeds |  |  |
| ☐Fast heartbeat |  | ☐Difficulty swallowing |  | ☐Hoarseness |  |  |
| ☐High blood pressure |  | ☐Painful urination |  | ☐Easy bleeding |  |  |
| ☐Low blood pressure |  | ☐Blood in urine |  | ☐Easy bruising |  | Females - Please complete |
| ☐Lightheadedness |  | ☐Frequent urination |  | ☐Rash |  | Menstrual flow: |
| ☐Dizziness/fainting |  | ☐Decrease in urine flow |  | ☐Changes in a mole |  | Reg Irreg Pain/cramps |
| ☐Heartburn |  | ☐Headaches, frequent |  | ☐Sore that won't heal |  | Days of flow: \_\_\_\_\_ |
| ☐Indigestion |  | ☐Loss of strength |  | ☐Insomnia |  | Pain or bleeding after sex |
| ☐Ankle/foot swelling |  | ☐Balance problems |  | ☐Depression |  | Number of pregnancies: \_\_\_ |
| ☐Nausea |  | ☐Pain, weakness or numbness in: |  | ☐Nervousness |  | Number of miscarriages: \_\_\_ |
| ☐Vomiting |  | ☐Arms ☐Hips ☐ Low back |  |  |  | Birth control method: \_\_\_\_\_ |
| ☐Vomiting blood |  | ☐Legs ☐Neck ☐ Shoulders |  |  |  | Menopause: |
| ☐Change in bowel habits |  | ☐Hands ☐Feet ☐ Abdomen |  |  |  | Yes No Age: |

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| Family History | | | | |
| Father ☐Living ☐Deceased at age \_\_\_\_\_ | | Mother ☐Living ☐Deceased at age \_\_\_\_\_ | | |
| Brother ☐Living ☐Deceased at age \_\_\_\_\_ | | Sister ☐Living ☐Deceased at age \_\_\_\_\_ | | |
| Brother ☐Living ☐Deceased at age \_\_\_\_\_ | | Sister ☐Living ☐Deceased at age \_\_\_\_\_ | | |
| Brother ☐Living ☐Deceased at age \_\_\_\_\_ | | Sister ☐Living ☐Deceased at age \_\_\_\_\_ | | |
|  |  |  |  |  |
| ☐Adopted/Family health history unobtainable | |  |  |  |
|  |  |  |  |  |
| Please check all that apply | | | | |
|  | Father | Mother | Brother(s) | Sister(s) |
| Denies significant symptoms |  |  |  |  |
| Alcoholism |  |  |  |  |
| Allergies |  |  |  |  |
| Alzheimer's |  |  |  |  |
| Aneurysm |  |  |  |  |
| Anxiety disorder |  |  |  |  |
| Arthritis |  |  |  |  |
| Asthma |  |  |  |  |
| Bleeding problems |  |  |  |  |
| Cancer (list type) |  |  |  |  |
| Drug dependence |  |  |  |  |
| Depression |  |  |  |  |
| Diabetes |  |  |  |  |
| GI disorders |  |  |  |  |
| Glaucoma |  |  |  |  |
| Heart attack |  |  |  |  |
| Heart disease |  |  |  |  |
| HIV |  |  |  |  |
| High cholesterol |  |  |  |  |
| Hypertension |  |  |  |  |
| Kidney disease |  |  |  |  |
| Liver disease |  |  |  |  |
| Lung disease |  |  |  |  |
| Mental/Psychiatric disorder |  |  |  |  |
| Migraines |  |  |  |  |
| Neurological disorder |  |  |  |  |
| Neuropathy |  |  |  |  |
| Seizure disorder |  |  |  |  |
| Stroke |  |  |  |  |
| Thyroid disorder |  |  |  |  |
| Other |  |  |  |  |
| Are there any religious or cultural factors that you would like us to consider when planning your health care? | | | | |
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| Health Maintenance | | | | |
| Please check whether you have had the following preventive services and enter the month & year of service. | | | | |
| Immunizations | Last Occurrence |  | Tests | Last Occurrence |
|  | Month/Year |  |  | Month/Year |
| Tetanus vaccine / Tdap |  |  | Breast cancer screening |  |
|  |  | ☐Mammogram bilateral |  |
|  |  | ☐Left breast ☐Right breast |  |
| Pneumonia vaccine |  |  | Cervical cancer screening |  |
| ☐Pneumovax 23 |  |  | ☐Pelvic exam |  |
| ☐Prevnar 13 |  |  | ☐Pap smear |  |
| ☐Vaxneuvance |  |  | ☐Positive ☐Negative |  |
| ☐Prevnar 20 |  |  |  |  |
| Influenza vaccine |  |  | Human papilloma virus screening |  |
|  |  | Positive Negative |  |
| Shingles vaccine |  |  | Colorectal cancer screening |  |
| ☐Zostavax |  |  | ☐Colonoscopy (next due in \_\_\_ years) |  |
| ☐Shingrix |  |  | ☐FOBT (stool lab test) |  |
|  |  |  | ☐Positive ☐Negative |  |
|  |  |  | ☐Flexible sigmoidoscopy |  |
|  |  |  | ☐Cologuard |  |
| Hepatitis A |  |  | Chest x-ray |  |
| Hepatitis B |  |  | Prostate-specific antigen (PSA) |  |
| Gardasil (HPV) |  |  | Bone density |  |
|  |  |  | Low-dose CT lung |  |
| Allergies | | | | |
| Please list any allergies to medications or foods and give the reaction you experience if eaten/taken. | | | | |
| Name of food / drug | | Symptom / Reaction | | |
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| Surgical and Hospitalization History | | |
| Please list all surgeries. Also list any non-surgical hospitalizations in the past 12 months. | | |
| Hospital / Surgeon | Date | Reason for admission/surgery |
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| Medications | | |
| Please list any medications you take, including over-the-counter meds, herbs, and supplements | | |
| Name | Dose | Frequency |
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| Care Team | |
| So we can best coordinate your care, please list any medical providers you see outside this practice | |
| **Allergist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Cardiologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Dentist / Oral Surgeon** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Endicrinologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Gastroenterologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Gynecologist (OB/GYN)** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Nephrologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Oncologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Opthamologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Orthopedist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Podiatrist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Psychiatrist / Psychologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Pulmonologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Urologist** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other** |  |
| Practice *AND* name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |