# *WELCOME!*

To Our Patients:

Thank you for choosing Progressive Medical Center to assist you in determining the source of your personal health issues. We pledge to you a caring, professional and sharing environment dedicated to getting you back on the right track in as natural a manner as possible. Your wellness is our goal!

Your visit to our medical facility will involve a thorough review of your medical history in order to evaluate proper treatment. This questionnaire will assist the physician in determining the appropriate standing orders for testing to assess for the root cause(s) of your medical condition.

You will be initially interviewed by one of our medical assistants/Registered Nurse/Physician Assistant to obtain a more detailed history. One of our licensed attending physicians, either Viktor Bouquette, M.D., Joanne Donaldson, M.D., Benjamin Johnston, Sr., M.D., Lucy Wallang, P.A., Lorena Williams, N.P., Melanie Wardle, N.P., DeAndra McDuffie, D N.P., Tane Patrono, N.P., Michelle Robinson, P.A., or Steve Eke N.P. who then decides which of our extensive array of tests to utilize in diagnosing and adequately assessing your specific condition.

***The cost for this initial office visit and examination will be $170 unless in network with Blue Cross Blue Shield PPO or Cigna POS/PPO.***

_____ _____
Patient/Authorized Person Signature Date

This paperwork is essential to your visit. To maximize your time with the physician, please initial that you understand this entire packet needs to be completed 30 min. prior to your appointment time. If your paperwork is not completed prior to your appointment time, your visit may need to be rescheduled.

_____(Initial)

We do require you to cancel or reschedule your appointment within **48hrs** of your scheduled appointment date & time. In order to reschedule or cancel your appointment, please call our office and speak with our New Patient Coordinator (770-676-6000, option 2). Cancellations after this time and no-shows are subject to the $25 cancellation fee.

_____(Initial)

In the course of your visits here, some of the previously ordered tests might indicate the need for further assessment, and therefore, other studies might be ordered. Again, these studies will be explained to you, staying true to our standard of always keeping the patient fully informed. Your participation in all decisions pertinent to your care is a vital part of our integrated treatment process.

At any time in the process, if you desire to speak with our financial counselor for more details on costs, payments, or your insurance coverage, we will be pleased to consult with you. It is our desire that you are comfortable with all of our medical and financial procedures. We want you to feel at ease and confident with all members of the Progressive Medical Center's team.

If you have any other questions, please feel free to ask any of our staff.

## Out of Network Insurance Provisions

In the course of diagnosis and treatment, patients at Progressive Medical Center undergo comprehensive laboratory testing and detailed evaluations. In network managed care programs, Medicare/ Medicaid, and HMO's, however, prefer a more simplified approach to testing and evaluations. As a result, Progressive Medical Center is not members of any In Network Managed Care, Medicare/ Medicaid, or HMO programs.

To avoid any inconvenience for our patients, Progressive Medical Center has developed procedures for payment arrangements when necessary. The mission and purpose of Progressive Medical Center is to work in harmony with our patients on all levels to address medical concerns and move toward a healthier state in life.

I, the undersigned, do hereby acknowledge and understand that Progressive Medical Center are out of network providers for most insurance carriers and that my own insurance carrier can change throughout the year. I acknowledge it is my responsibility to notify the billing department of any insurance updates.

_____ _____

Patient/Authorized Person Signature Date

## Notice to Patients

| | | | |
|---|---|---|---|
| Diana Hubbard, ND | Krishna Muhammad, ND | Jenna Davis, ND | Marcia Williams, ND |
| James Munro, ND | Lindsay Moreau, ND | Kasey Holland, ND | Mallory Howe, ND |

This notice is provided to you pursuant of law. We have other physicians on staff this does not apply to. The practitioners above are registered Doctors of Naturopathic Medicine, and under the scope of practice for Naturopathy, are not practicing as licensed medical doctors and therefore do not practice "the application of scientific principles to prevent, diagnose and treat physical and mental diseases, disorders, and conditions and to safeguard the life and health of any person." A person registered to practice naturopathy or naturopathic healing under the law may counsel individuals and treat human conditions through the use of "naturally occurring substances."

The underlying causes of disease can be improper diet, unhealthy habits and environmental factors that cause biological imbalance. A classic naturopath specializes in wellness; the teaching of natural lifestyle approaches to facilitate the body's healing and health building potential.

I fully understand that the above named individuals are not medical doctors. This individual may counsel me on nutrition, supplements, and better health practices, but will not diagnose or prescribe remedies for disease. Furthermore, I understand that I will be diagnosed by a licensed medical physician during my visit at this office.

_____ _____

Patient/Authorized Person Signature Date

**NOTIFICATION TO PATIENTS**

**Disclosure of Lab services:**

You have the right to choose where you receive medical and laboratory services. Your physician/advanced practitioner may order specialty lab testing when they deem it is medically necessary. Physicians and Advanced Practitioners have **no financial relationship** with any reference laboratories including, LabCorp of America, Quest Diagnostics, American Clinical Labs, Dunwoody Labs, Doctor's Data, Precision Labs or Vibrant Laboratory.

The Medical Management Company (which is not owned by your physician) reserves the right to develop a business relationship with Labs. You have the right to choose where you receive laboratory services including an entity in which the Medical Management Company may have a business relationship with.
You will not be treated differently by your physician if you choose to use a different laboratory. If desired, your physician can provide information about alternative laboratories, if one is available for your specific tests.

As a courtesy to our patients, The Medical Management Company will be collecting deductible and co-insurance fees for Mountain Lakes Medical Center. The billing company sends the balance bill to the management company, who will then send this to patients.

## Acknowledgment of Disclosure

*By signing this Acknowledgment of Disclosure, you acknowledge that you have read and understand the foregoing Notification to Patients regarding physician ownership.*

_____ _____ _____

Signature of Patient Date

_____

Type or Print Name of Patient

# Assignment of Benefits Authorization / Release Form

Patient's Full Legal Name: _____ Preferred: _____Maiden Name: _____

Date of Birth: _____ Age: ____ Sex: M / F SSN: _____ Race: _____ Ethnicity: _____

Marital Status: M / S / D Driver's License State/#: _____ Primary Language: _____Religion: _____

Address: _____City: _____ State: _____ Zip: _____ County: _____

Home Phone: (____) _____Work: (____) _____ Cell: (____) _____ Use for Primary: Hm / Wk / Cell

Email Address: _____

Employer: _____ Position: _____

Parent or Spouse Name: _____ Insured Party Y / N SSN: _____ Date of Birth: _____

Work Number: (___) _____Cell: (____) _____ Parent or Spouse's Employer: _____

Emergency Contact :_____ _____Relationship:_____ Home/Cell: (____) _____

Pharmacy Name/Phone: 1) _____ 2) _____

Patient's Primary Care Dr: _____ Phone Number: _____ Date Last Seen: _____

How did you hear about us? Radio / Friend / Family / Existing Patient / Internet / Physician / Expo / Other:_____

***ALL FEES PAYABLE AT TIME OF SERVICE UNLESS SPECIAL ARRANGEMENTS ARE MADE.***

## ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AN APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Progressive Medical Center, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for medical/healthcare services that have or will be rendered and for any supplies, tests, or medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan, ERISA plan, PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This document includes, but is not limited to, a designation that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment and/or designation will remain in effect unless revoked in writing, and a photocopy or scan is to be considered as valid and enforceable as the original.

Signed this _____ day of _____ 20____.

X_____
Patient Signature

_____
Please print Patient name

X_____
Signature of Guardian if applicable

_____
Please print Guardian name

# Authorization for Disclosure of Health Information

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law.

Examples of some instances in which we are required to disclose your PHI include:
Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.
Progressive Medical Center will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

Patient Name: _____ Date: _____

Signature: _____

Guardian/ Parent name: _____ Signature: _____

## *My health information may be disclosed to and used by the following individual:*

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: Progressive Medical Center.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ _____

Signature of patient or legal representative Date

# Medical History

Patient's Name: _____Date of Birth:_____Age: _____ Date: _____

What is the main problem that brought you in today? _____

How long have you been having symptoms? _____

**Current Medications:**

_____
_____
_____
_____
_____

**Current Supplements:**

_____
_____
_____
_____
_____

**Allergies:**

| Drugs | Foods | Environmental (e.g. pollen) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| | Tested Y / N | Tested Y / N |

**Past Medical History:**

Have you had any of the following medical issues?

| Condition | Yes | No | Current treatment | Date Began | Date Resolved |
|---|---|---|---|---|---|
| ADD/ADHD | | | | | |
| Alcoholism/Drug addiction | | | | | |
| Allergies | | | | | |
| Anemia | | | | | |
| Anxiety | | | | | |
| Arthritis | | | | | |
| Asthma | | | | | |
| Autoimmune Disease Type | | | | | |
| Cancer Type: | | | | | |
| Chemical Sensitivities | | | | | |
| Chronic Fatigue | | | | | |
| Depression | | | | | |
| Diabetes | | | | | |
| Eczema | | | | | |
| Fibromyalgia | | | | | |
| GERD/reflux | | | | | |
| Headaches/migraines | | | | | |
| Heart Disease | | | | | |
| High Blood Pressure | | | | | |
| High Cholesterol | | | | | |
| **Condition** | **Yes** | **No** | **Current Treatment** | **Date Began** | **Date Resolved** |
| Irritable Bowel Syndrome | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Lyme Disease | | | | | |
| Menopause | | | | | |
| Mental Illness | | | | | |
| Mononucleosis | | | | | |
| Obesity | | | | | |
| Ovarian Cysts (PCOS) | | | | | |
| Psoriasis | | | | | |
| Prostate Disease | | | | | |
| Recurrent Strep infections | | | | | |
| Thyroid Disease | | | | | |
| Vaginal Infections | | | | | |
| Other | | | | | |
| | | | | | |

**Hospitalizations:** **Date:** **Issue:** **Age:**

_____ _____ _____
_____ _____ _____
_____ _____ _____

**If female: Do you have any of the following:**

| | Yes | No |
|---|---|---|
| Irregular menstrual cycles? | | |
| Extreme heavy bleeding or cramping with menstrual cycles? | | |
| Extremely light bleeding with cycles? | | |
| Breast tenderness as part of PMS symptoms? | | |
| Sugar cravings or mood swings as part of PMS symptoms? | | |

Have you been pregnant? Yes No If yes, ages: _____
If no, have you tried to get pregnant without success? Yes No
When was your last Menstrual Cycle? Date: _____
When was your last: Pap _____ Mammogram _____ Bone Density _____
Have you used birth control pills? Yes No If yes, how long _____

**If male: Do you have any of the following:**

| | Yes | No |
|---|---|---|
| Problems attaining/maintaining an erection | | |
| Difficulty with urination including decreased stream or increased frequency? | | |

**Family Medical History:**

Mother's age (at death if deceased): _____
Any medical conditions: _____
Father's age (at death if deceased): _____
Any medical condtions: _____
Siblings' ages and medical condtions: _____
Other family members with chronic health conditions (e.g-diabetes, heart disease, thyroid disease):
_____

**Social history:**

Please circle those that apply: Single Married Divorced
Please circle any of the following substances that you use regularly: Tobacco / Alcohol / Coffee / Recreational Drugs

**Dental history:** Please circle those that apply: Mercury filling(s) / Tooth Abscess(es) / Root Canal(s)

_____

_____ _____ _____ _____
Patient/Authorized Person Initials Date Physician's Initials Date

**PRIMARY COMPLAINT(s): _____**

_____

**Appx. date of onset: _____** **Symptoms began: __ Gradually: __ Suddenly**

# Symptom and Ailments Questionnaire #1

***Please check the appropriate box for each question.***

| **Symptoms – Please Circle One or all that apply on each line:** | **Frequently** | **Occasionally** | **Rarely** | **Never** |
|---|---|---|---|---|
| Cold hands, feet, low body temperature | | | | |
| Fatigue/ tiredness | | | | |
| Inability to lose weight despite dieting | | | | |
| Poor memory | | | | |
| Poor concentration | | | | |
| Constipation | | | | |
| Diarrhea | | | | |
| Hair loss | | | | |
| Depression | | | | |
| Anxiety/ nervousness | | | | |
| Irregular heart beats | | | | |
| Trouble sleeping | | | | |
| Muscle weakness | | | | |
| Muscle aches | | | | |
| Joint pain | | | | |
| Headaches | | | | |
| Early morning stiffness | | | | |
| Easy fatigue from exercising | | | | |
| Sleepiness in the afternoon | | | | |
| Dizzy/ lightheaded | | | | |
| Sugar cravings | | | | |
| Loss of voice / hoarseness | | | | |
| Shaky or irritable when hungry | | | | |
| Thyroid disease | | | | |
| Sense of fullness during and after meals | | | | |
| Belching/ burping/ bloating/ gas | | | | |
| Rectal itching/ nasal itching | | | | |
| Toe fungus, jock itch, or athlete's foot | | | | |
| High sensitivity to smells | | | | |
| Chronic or long term hives | | | | |
| Bad breath | | | | |
| Sinus or breathing problems | | | | |
| Easy bruising | | | | |
| Slow wound healing | | | | |
| | | | | |
| Average bowel movements per day? | (1) | (2) | (3) | (4+) |

_____ _____ _____ _____

Patient/Authorized Person Initials Date Physician's Initials Date

# Symptom and Ailments Questionnaire #2

***Please check the appropriate box for each question.***

| **Symptoms – Please Circle One or all that apply on each line:** | **Frequently** | **Occasionally** | **Rarely** | **Never** |
|---|---|---|---|---|
| Vaginal burning, itching or discharge | | | | |
| Prostatitis or prostate cancer | | | | |
| Mood swings | | | | |
| Endometriosis or infertility | | | | |
| Cramps or menstrual irregularities | | | | |
| Attacks of anxiety or crying | | | | |
| Bladder / kidney infections | | | | |
| Drowsiness | | | | |
| Irritability | | | | |
| Eczema or psoriasis | | | | |
| Itchy skin or eyes | | | | |
| Chronic hives (urticaria) | | | | |
| Indigestion or heartburn | | | | |
| Decreased body hair | | | | |
| Sensitivity to milk, wheat or foods | | | | |
| Decreased sex drive | | | | |
| Dry mouth or throat | | | | |
| Bad breath | | | | |
| White tongue | | | | |
| Excessive foot, hair or body odor | | | | |
| PMS pre-menstrual syndrome | | | | |
| Frequent sore throats | | | | |
| Laryngitis, loss of voice | | | | |
| Recurring bronchitis | | | | |
| Pain or tightness in the chest | | | | |
| Shortness of breath | | | | |
| Spots in front of eyes | | | | |
| Burning or tearing eyes | | | | |
| Recurring infections in eyes | | | | |
| Ear pain or ringing | | | | |
| Salt Cravings | | | | |
| Other symptoms needing consideration: | | | | |
| | | | | |
| | | | | |
| | | | | |

_____ _____ _____ _____

Patient/Authorized Person Initials Date Physician's Initials Date

# Symptom and Ailments Questionnaire #3

***Please check the appropriate box for each question.***

| **Symptoms and Ailments: Please circle one or all that apply on each line:** | ***YES*** | ***NO*** |
|---|---|---|
| Have you taken multiple courses of a broad-spectrum antibiotic drug—even in a single dose? | | |
| Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs? | | |
| Are you bothered by memory or concentration problems e.g. do you sometimes feel 'spaced out'? | | |
| Do you feel 'sick all over' yet, in spite of visits to many different physicians, no cause has been found? | | |
| Have you been pregnant? | | |
| Have you taken birth control pills longer than 2 years? | | |
| Have you taken steroids orally, by injection or inhalation? | | |
| Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke symptoms? | | |
| Does tobacco smoke *really* bother you? | | |
| Are your symptoms worse on damp, muggy days or in moldy places? | | |
| Have you had athlete's foot, ring worm, 'jock itch' or other chronic fungus infections of the skin or nails? | | |
| Do you crave sugar? | | |
| Do you have high blood pressure? | | |
| Have you ever had angina or a heart attack? | | |
| Have you ever had a stroke? | | |
| Do you have diabetes? | | |
| Do you have swelling that is not known to be the result of another health issue? | | |
| Do you smoke? | | |
| Do you have high cholesterol? If yes, what is your cholesterol number? _____ | | |
| Have you ever had coronary bypass surgery? | | |
| Is there history of heart disease in your family? | | |
| Have you been diagnosed with sleep apnea? | | |

**24 hr Food Intake:**

When did you last eat? _____ hrs ago

What did you have for breakfast today: _____

Lunch (yesterday or today):_____

Dinner (yesterday):_____

Snacks (past 24 hours):_____

Beverages (past 24 hours):_____

_____ _____ _____ _____

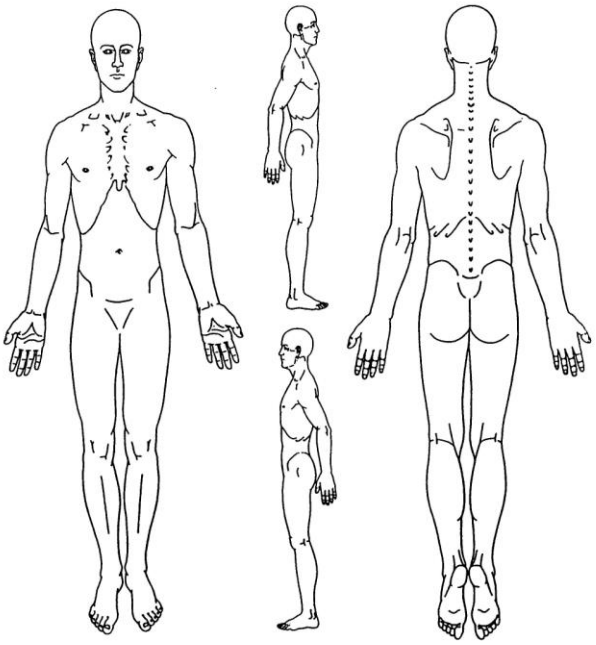
Patient/Authorized Person Initials Date Physician's Initials Date

# Pain Symptoms Questionnaire

**Please check the appropriate box for each question.**

Using the diagram below, indicate any areas you are feeling pain by marking a

PPP = Pain NNN= Numbness TTT = Tingling BBB = Burning CCC= Cramping XXX = Other



On a scale of 1-10, with 10 being the worst possible pain, what is your level of pain?

1 2 3 4 5 6 7 8 9 10

Please indicate any other symptoms that you have experienced:

_ Dizziness _ Memory Loss _ Numb Feet/ Toes
_ Irritability _ Ears Ringing _ Back Pain
_ Difficulty Sleeping_ Fatigue _ Jaw Problems _ Chest Pain _ Arm/ Shoulder Pain_ Leg Pain _ Back Stiffness
_ Blurred Vision _Numb Hand/ Fingers _ Tension
_ Low Back Pain _ Neck Stiffness _Shortness of Breath
_ Nausea _ Buzzing in Ear _ Neck Pain _ Upset Stomach_

Other: _____

_____

**Circle Quality of Pain:**

Stabbing Shooting Dull Constant Intermittent Better /Worse with heat Better/Worse with ice
Better/Worse with movement Better/Worse sitting Better/Worse standing Better/Worse lying down

If yes,
How many days a week do you exercise? _____ How long? _____

What type of exercise (s)? _____

Have you ever seen a pain management specialist? NO__ YES__

If yes, what treatments are you currently receiving on a regular basis? (Acupuncture, physical therapy, medication…)_____

_____ _____ _____ _____
Patient/Authorized Person Initials Date Physician's Initials Date

# Environmental Profile

According to the World Health Organization as much as 65% of all illnesses can be caused or made worse by the indoor environment. Numerous chronic diseases, which were once rare, are becoming commonplace as the levels of toxins present in our environment continue to escalate. Many times medical treatments are rendered ineffective if the environment in which a patient lives is not conductive to the healing process. During the course of your medical treatment the physician obtains a complete profile of your living environment. This will enable Progressive Medical Center to determine if your illness is caused or worsened by your living or working environment and to specifically individualize a treatment program for optimal results.

***Please circle one or all that apply on each line and answer the following questions by checking YES or NO:***

| Question | Yes | No |
|---|---|---|
| Are pesticides in your home or office? | | |
| Do you use natural cleaning and laundry products? | | |
| Is the construction of your house less than 15 years old? | | |
| Have you had plumbing leakage, wet carpets or other water damage anywhere in your home? | | |
| Do you have animals live indoors? | | |
| Do you or your neighbors use lawn chemicals? | | |
| Do you have moldy odors, mildew or visible molds anywhere in your home? | | |
| When turning on your heating or air conditioning system(s) do you smell foul or moldy odors? | | |
| Does the dust in your home reappear shortly after dusting? | | |
| Do you have "blown-in" insulation in your attic? | | |
| Are you, or is anyone in your home, experiencing any chronic ailments such as asthma, allergies, sinus infections, respiratory problems, or frequent cold or flu-like symptoms? | | |
| Have you ever had bird, rat, mouse or any rodent infestation in your home? | | |
| Do you have a "crawlspace" or an unfinished basement in your home? | | |
| Do you feel better after you leave your home or office for a extended period of time? | | |
| Do you use only natural products for your skin? | | |
| Do you have moldy odors or visible molds in your workplace? | | |
| Has there ever been water stains on the ceiling tiles, chemical odors, dirty air vents or excessive dust intrusion in your home or workplace? | | |
| Do you frequently feel tired or run-down at the end of a workday? | | |
| Do your family members and co-workers frequently complain of headaches, colds or flu-like symptoms? | | |
| Is smoking permitted in your workplace or home? | | |
| Do you have carpeting in your home or office? | | |
| Do you use a filter for all drinking, cooking and shower/bath water? | | |
| Do you have an air filter in your home or work place? | | |

What is your current occupation? _____
If less than one year, what was your prior occupation? _____

_____ _____ _____ _____
Patient/Authorized Person Initials Date Physician's Initials Date

# No Cost Tests

As a Service to New Patients at Progressive, we now offer Brain Mapping and Allergy Tests. These tests take approximately 1 hour to perform both. These tests are no-cost to you and are applicable based on your symptoms. In the case that your insurance will cover this based on your symptoms, we will bill this to your insurance.

## Symptom and Ailments Questionnaire #4

***Please check the appropriate box for each question.***

| **Brain Mapping Symptoms. Please circle one or all that apply on each line:** | ***YES*** | ***NO*** |
|---|---|---|
| Poor Memory/ Concentration | | |
| Anxiety | | |
| Depression | | |
| Irritability | | |
| Insomnia or Trouble Sleeping | | |
| | | |
| **Allergy Symptoms. Please circle one or all that apply on each line:** | | |
| Seasonal Allergies/ Asthma | | |
| Chronic Sinus Infection | | |
| Chronic Congestion or Runny Nose | | |
| Burning or Watery Eyes | | |
| Frequent Puffiness in Face | | |
| Eczema and Other Skin Diseases | | |
| Difficulty Breathing | | |
| Chronic Fatigue | | |

_____ _____ _____ _____

Patient/Authorized Person Initials Date Physician's Initials Date