



## Review of Systems

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask a member of the office staff

**Const. (Health in General)**  No Problems; Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, memory loss, brain fog, fatigue. Other: \_\_\_\_\_

**Eyes**  No Problems; Visual changes, headache, eye pain, diplopia (double vision), tearing, scotomata (blind spots), floaters. Other: \_\_\_\_\_

**Ears, Nose, Mouth & Throat**  No Problems; Difficulty with hearing, ringing in ears, ear pain, vertigo, sinus problems, runny nose, post-nasal drip, nosebleeds, mouth sores, loose teeth, bleeding gums, sore throat, pain with swallowing, facial pain or numbness. Other: \_\_\_\_\_

**C-V (Heart & Blood Vessels)**  No Problems; Irregular heartbeat, chest pains, shortness of breath, swelling of feet or legs, high blood pressure, low blood pressure, pacemaker, heart attack, stroke. Other: \_\_\_\_\_

**Resp. (Lungs & Breathing)**  No Problems; Shortness of breath, chronic cough, wheezing, COPD, asthma, tuberculosis, oxygen at home, coughing up blood. Other: \_\_\_\_\_

**GI (Stomach & Intestines)**  No Problems; Heartburn, constipation, foods allergies, diarrhea, abdominal pain, nausea, vomiting, blood in stools, unexplained change in bowel habits, diabetes, low blood sugar.

Other: \_\_\_\_\_

**GU (Kidney & Bladder)**  No Problems; Painful urination, frequent urination, urgency, bladder problems, incontinence, renal failure.

Other: \_\_\_\_\_

**MS (Muscles, Bones, Joints)**  No Problems; Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain, numbness. Other: \_\_\_\_\_

**Integ. (Skin, Hair & Breast)**  No Problems; Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: \_\_\_\_\_

**Neurologic (Brain & Nerves)**  No Problems; Frequent headaches or migraines, double vision, weakness, change in sensation, vertigo, dizziness, tremor, loss of consciousness, seizures, episodes of visual loss.

Other: \_\_\_\_\_

**Psychiatric (Mood & Thinking)**  No Problems; Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: \_\_\_\_\_

**Endocrinologic (Glands)**  No Problems; Intolerance to heat or cold, frequent hunger/urination/thirst, changes in sex drive, thyroid trouble. Other: \_\_\_\_\_

**Hematologic (Blood/Lymph)**  No Problems; Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: \_\_\_\_\_

**Allergic/Immunologic**  No Problems; Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: \_\_\_\_\_

**For Women Only: (GYN)**  No Problems; Irregular periods, heavy bleeding/clotting, abnormal vaginal discharge, pelvic pain, hysterectomy with or w/out removal of ovaries, night sweats, hot flashes, vaginal dryness, frequent cramping. Other: \_\_\_\_\_

Date of last menstrual: \_\_\_\_/\_\_\_\_/\_\_\_\_.

**For Men Only:** Decreased muscle mass/strength, atrophy, erectile dysfunction, decreased libido, history of prostate problems, history of elevated PSA.

Other: \_\_\_\_\_

Initial \_\_\_\_\_

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## **PURPOSE OF THIS VISIT**

Reason for this visit – Main Complaint: \_\_\_\_\_

When did this condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ Did it begin:  Gradually  Suddenly  
Does your complaint interfere with:  Work  Sleep  Hobbies  Daily Routine  Explain \_\_\_\_\_

Have you experienced this condition before?  Yes  No If YES, explain \_\_\_\_\_

Who have you seen for this? \_\_\_\_\_ What did they do? \_\_\_\_\_

How did you respond? \_\_\_\_\_

Who referred you to this practice? \_\_\_\_\_

Please list any other complaints:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## **WOMEN ONLY**

First day of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are your cycles regular?  Yes  No – If no, how often? \_\_\_\_\_

How long do your cycles last? \_\_\_\_\_ days

Is your flow:  Light  Medium  Heavy

Do you have pain or bleeding after sexual intercourse?  Yes  No

Have you ever been pregnant?  Yes  No – If Yes, how many children? \_\_\_\_\_

Date of last PAP smear: \_\_\_\_/\_\_\_\_/\_\_\_\_. Was it normal?  Yes  No

Date of last mammogram/breast exam: \_\_\_\_/\_\_\_\_/\_\_\_\_. Was it normal?  Yes  No

Do you perform monthly self-breast examinations?  Yes  No

## **MEN ONLY**

Do you have an enlarged or infected prostate?  Yes  No

Pus or discharge from the penis?  Yes  No

Rupture or swelling in the groin?  Yes  No

Nodule in testicle which is growing larger?  Yes  No

Problem with sexual function?  Yes  No

Pain or tenderness in the groin area?  Yes  No

Initial \_\_\_\_\_

**Health Questionnaire**  
**Do you have symptoms of chemical or heavy metal toxicity?**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*(Put an 'x' by the ones that apply to you)*

1. \_\_\_ Do you have environmental and/or food allergies and sensitivities?
2. \_\_\_ Are you prone to mood swings?
3. \_\_\_ Do you have digestive problems and/or leaky gut syndrome?
4. \_\_\_ Are you anxious and very irritable at times?
5. \_\_\_ Do you suffer with irritable bowel syndrome (IBS), colitis, or Crohn's Disease?
6. \_\_\_ Are you experiencing loss of memory and forgetfulness?
7. \_\_\_ Do you have "brain fog"?
8. \_\_\_ Do you have 'speech difficulties'?
9. \_\_\_ Do you have high blood pressure (hypertension)?
10. \_\_\_ Are you often extremely fatigued (chronic fatigue)?
11. \_\_\_ Do you now take or have you taken anti-depressants (depressed)?
12. \_\_\_ Have you had a liver disease, and your liver is damaged?
13. \_\_\_ Do you have unexplained headaches?
14. \_\_\_ Do you have muscle tremors?
15. \_\_\_ Is your sense of smell greater than most people?
16. \_\_\_ Do you have an intolerance for alcoholic drinks?
17. \_\_\_ Are you overly sensitive to tobacco smoke, perfumes, paint fumes and other chemical odors?
18. \_\_\_ Have you found that there are many medications you can't take, and some vitamin and mineral supplements make you feel worse?
19. \_\_\_ Have you discovered that you feel worse when shopping in certain stores, such as hardware stores, or in the cleaning section of grocery stores (where chemicals are)?
20. \_\_\_ Are you allergic to many things?
21. \_\_\_ Do you have a weakened immune system, catch colds frequently?
22. \_\_\_ Do you have an autoimmune disorder?
23. \_\_\_ Are you tired and sick a lot, no matter what remedies you try?
24. \_\_\_ Do you have any silver fillings?
25. \_\_\_ Do you have sore and/or receding gums?
26. \_\_\_ Do you often have a metallic taste in your mouth?
27. \_\_\_ Do you have sensitive teeth?
28. \_\_\_ Do you smoke?
29. \_\_\_ Do you have skin problems?
30. \_\_\_ Do you often have chronic unexplained pain, especially in extremities?
31. \_\_\_ Do you have severe chronic insomnia?
32. \_\_\_ Have you found that you cannot lose weight, no matter how hard you try?
33. \_\_\_ Do you take prescription and/or recreational drugs on a regular basis?
34. \_\_\_ Have you developed neurological symptoms such as tingling in the extremities, muscle tics or twitches, or an unsteady gait?
35. \_\_\_ Do you often have night sweats?
36. \_\_\_ Do you have dark circles under the eyes?
37. \_\_\_ Do you have low body temperature?
38. \_\_\_ Are your hands and feet usually cold?
39. \_\_\_ Do you have muscle and joint pain?
40. \_\_\_ Do you have Fibromyalgia?
41. \_\_\_ Are you prone to rashes that you cannot heal?
42. \_\_\_ Are you now, or have you been exposed to toxic chemicals or metals either at home or in your workplace?
43. \_\_\_ Do you work in agriculture, drug development, or in manufacturing?

**Initial** \_\_\_\_\_

**Allergies**

Please check all that apply

- Local Anesthetics
- Penicillin or other antibiotics
- Latex
- Codeine or other narcotics
- Aspirin
- Other: \_\_\_\_\_

**Social History**

Y=Yes, N=No, O=Occasionally

- Do you smoke? \_\_\_\_\_ Packs per day
- Do you chew tobacco? \_\_\_\_\_ Amount per day
- Do you have a history of drug abuse?
- Do you drink alcohol? \_\_\_\_\_ Amount per week
- Do you have a history of alcohol abuse?
- Other: \_\_\_\_\_

Do you consider yourself to be in good health? **Yes No** Height: \_\_\_\_\_ Current weight: \_\_\_\_\_

Are you currently under the care of a physician? **Yes No**

If so, who? \_\_\_\_\_

What condition(s) are they treating currently? \_\_\_\_\_

Have you ever been hospitalized? **Yes No**

If so please list the dates and reasons for Hospitalization: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Family History**

- Cancer; Who: \_\_\_\_\_
- Diabetes; Who: \_\_\_\_\_
- Heart disease; Who: \_\_\_\_\_
- High Blood Pressure; Who: \_\_\_\_\_
- Thyroid Disorder; Who: \_\_\_\_\_
- Anesthetic Problems; Who: \_\_\_\_\_

I certify that I have read and understand the questions above. I acknowledge that I will have the opportunity to discuss my health history with my physician. I will not hold my physician or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Consent to Antibody Testing, in the event of accidental exposure to blood or other bodily fluids through needle stick, cut, mucous membrane contact, or the like, the undersigned consents to appropriate tests for the presence of Hepatitis B & C and HIV, which is the virus believed to cause AIDS. The patient further agrees to hold harmless Preventive Medicine Anti-Aging Chelation, Inc., it entities and all employees should accidental exposure occur. The patient will be informed of any positive results, and all such results will be treated as confidential by Preventive Medicine Anti-Aging Chelation, Inc. There is no charge to the patient.

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## **CONSENT FOR TREATMENT**

This **CONSENT FOR TREATMENT** is made and entered into this the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_, by and between Preventive Medicine Anti-Aging Chelation, Inc. ("Physician") and \_\_\_\_\_("Client").

I hereby state that I have honestly and without exaggeration or omission, completed the attached "Patient Health History & Questionnaire". I also state that I have disclosed any and all information that might reasonably be considered relevant to decisions made by Physician regarding my care. I have disclosed **all past illnesses**, particularly those involving any form of cancer. I also state that I have disclosed all medications that I am taking at the present time and will inform Physician of any medications that may be prescribed now and in the future by other physicians. I also state that I have disclosed the past and present use of any substances including prescribed or nonprescription drugs, alcohol, steroids, vitamins, and dietary supplements. I hereby waive any claim or defense and hold harmless Preventive Medicine Anti-Aging Chelation, Inc. ("Physician") for any harm or injury I sustain as a result of my failure to fully disclose all relevant facts about my physical and medical condition to Physician. I hereby waive any claim or defense and hold harmless Preventive Medicine Anti-Aging Chelation, Inc. ("Physician") for any harm or injury I sustain as a result of my failure to fully comply with the method of treatment and dosage schedule prescribed by Physician. I agree to immediately cease any medical treatment prescribed by Physician in the event of any adverse response or side effect arising from prescribed treatment and to provide immediate written notice of such adverse response or side effect(s) to Physician via fax to (706) 891-1202. I agree to comply with the prescribed instructions for use of all medications prescribed by Physician. I agree all medications are for my personal use and are not to be used by anyone other than myself.

I understand that the practice of medicine is not an exact science and that all diagnosis and treatment may involve risks of injury, including but not limited to permanent injury and death. I acknowledge that no guarantees have been made to me as to the result of diagnostic testing analysis of test results, examination of medical history, or treatment by Physician.

I am or have been made aware to my satisfaction of the nature, risk, possible alternative methods of treatment, possible consequences, and possible complications involved in a course or treatment utilizing hormone replacement therapy. I am also aware that some studies exist that show a possible connection between replacement therapy and cancer. I am also aware that in the event that I develop some form of cancer, hormones that I am taking may make cancer worse. Replacement of hormones may, in some cases, cause a decrease in the body's natural ability to produce those hormones. Protocols are designed to limit that possibility, but that facts do not constitute hormone replacement therapy and, if accepted, that I be given hormone replacements.

I have read and understand the forgoing **CONSENT FOR TREATMENT** and have signed the same as by voluntary act and deed.

**Please Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please Sign Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_





**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS  
AS WELL AS AN  
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA  
REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Preventive Medicine Anti-Aging and Chelation Therapy, Robert A. Burkich MD, Jimmy Diaz MD, Paula Cook FNP, Tiffany Yin FNP, Angel Nofziger FNP, 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 any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

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 (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/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). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and 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 and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) 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, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

X \_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(please print patient name)

X \_\_\_\_\_  
(signature of Guardian if applicable)

**Notification Policy**

We are now offering a reminder service to better help you remember your appointment date and time. If you would like to utilize these services please select how you would like to be reminded and sign below.

Phone Call: \_\_\_\_\_ Text Message: \_\_\_\_\_ E-Mail: \_\_\_\_\_

\*Text message rates may apply depending on your phone carrier and contract

### Release of Information

Please list individuals who have permission to receive information on your behalf:

- 1. Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_
- 2. Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_
- 3. Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### Cancellation Policy

In order to serve our patients better, we have instituted a cancellation policy. If you cannot make it to your appointment please contact us 24 hours in advance to cancel your appointment. **If you DO NOT cancel 24 hours in advance you will be charged a no-show fee of \$50.00.**

### Insurance Consent

Insurance is considered a method of reimbursing you “the patient” for fees paid to the doctor **and is not a substitute for payment.** Some companies pay a fixed allowance for certain procedures and others pay a percentage of the services charged. Please remember: **It is your responsibility to pay any deductible amount, co-pays, and any other balance not paid by your insurance company.** Initial: \_\_\_\_\_

If this account is assigned to an attorney for suit and/or turned over to collections, I understand that I will be fully and wholly responsible for all attorney fees, court costs and the full costs of collections incurred, by what is herein referred to as the practice (and its entities). Initial: \_\_\_\_\_

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my, herein referred to as the patients records. Initial: \_\_\_\_\_

### Insurance Authorization and Assignment

I hereby authorize Preventive Medicine Anti-Aging and Chelation Therapy (and its entities) to furnish information to the insurance carriers, and I hereby assign to all physicians all payment for medical services. **I understand that I am responsible for any and all no/non covered fees.**

### Payment Authorization

It is a courtesy for our office to file your insurance; however you are responsible before seeing your physician to provide your co-pay, deductible and/or percentage, which the insurance company will not pay. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor your account will be given to our collection agency and you will be responsible for additional collections (*i.e.*, interest and attorney’s expenses incurred) if applicable.

\*I, \_\_\_\_\_, have fully read and understand the above statement of payment policy. I also state that all of the above information is the most current and updated information.

**\*Patient’s Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_