Midland Hearing Associates

Patient Name: _____

Address: _____

_____

(City) *(State)* *(Zip)*

Phone Number: *Home* _____

Work _____

Cell _____

Email _____

Patient Social Security #: _____ *Sex:* _____

Patient Date of Birth: _____ *Age:* _____

Primary Care Physician: _____

Parents or Spouse: _____

How did you hear about us*?* ___ *Doctor* ___ *Friend* ___ *Internet* ___ *Yellowpages*

___ *Newspaper* ___ *Other:* _____

Do you have a Facebook page? _____ ***Yes*** _____***No***

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ *By checking this box and signing below, I acknowledge that I have reviewed a copy of Midland Hearing Associates' Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website and that any revised Notice of Privacy Practices will be made available.*

_____ _____

Signature of patient or personal representative ***Date***

INSURANCE INFORMATION:

***** We will need to make a copy of your license and insurance card(s). *****

Primary Insurance Company: _____

Insured's Name (if different than the patient): _____

Insured's Date of Birth: _____ *SSN:* _____

Employer: _____ *Group #:* _____

Secondary Insurance Company: _____

Insured's Name (if different than the patient): _____

Insured's Date of Birth: _____ *SSN:* _____

Employer: _____ *Group #:* _____

STANDARD AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO

Midland Hearing Associates, Inc.
One Wellness Blvd., Suite 108
Irmo, SC 29063

I hereby authorize my insurance benefits to be paid directly to Midland Hearing Associates, Realizing I am responsible to pay noncovered services, and hearby authorize the release of any pertinent medical/audiological information to my insurance carrier(s) as necessary to process a claim. I understand that this information or a photostatic copy of the original shall be valid.

Signature _____

****** Can confidential messages (i.e., appointment reminders) be left on your telephone answer machine, voicemail or sent to you via email?***

YES_____ NO_____

Authorization to Use and Disclosure of Health Information

I request and authorize Midland Hearing Associates to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations. **PLEASE CHECK ONE**

- ☐ I consent to Midland Hearing Associates releasing protected health as detailed below.
- ☐ I prohibit Midland Hearing Associates from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

_____

_____

For the Purpose of:

_____

_____

Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing

I authorize Midland Hearing Associates to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Midland Hearing Associates or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations. **PLEASE CHECK ONE**

☐ *I Authorize Midland Hearing Associates to use and disclose medical information for any and all marketing purposes and understand that Midland Hearing Associates or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential situations/persons/class of persons/organizations to whom information may be disclosed is included below.*

☐ *I request an Authorization form for each instance Midland Hearing Associates intends to use and disclose medical information for any marketing purposes and understand that Midland Hearing Associates or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.*

☐ *I prohibit Midland Hearing Associates from using and disclosing medical information for any marketing purposes.*

A list of anticipated situations and/or potential persons/class of persons/organizations to whom information may be disclosed:

Information mailed to your home concerning our practice, newsletters regarding hearing healthcare, updates on technology, reminders for check ups and warranty renewal, or birthday/Christmas Cards. This information would be sent to you by Midland Hearing Associates or a hearing aid manufacturer.

**** Please list below in any instance where you would not want any of the above sent to you.***

_____

_____

If you need assistance in completing the authorization form, please contact Melissa Kednocker at betterhearing@midlandhearing.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by ***Midland Hearing Associates****.*

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by requesting to sign a revocation form and returning it to ***Midland Hearing Associates.***

I authorize Midland Hearing Associates' use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Midland Hearing Associates cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Signature of patient or personal representative ***Date***

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. ABOUT THIS NOTICE

Midland Hearing Associates is committed to protecting your health information. This Notice of Privacy Practices ("Notice") is provided pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as revised in the 2013 HIPAA Omnibus Rule . This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or audiological/health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights and our duties with respect to your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present or future physical or mental health/condition and related audiological/health care services. We must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact our Privacy Officer, Melissa Kednocker, at (803) 765-1919 ext. 1 or betterhearing@midlandhearing.com.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made.

1. Treatment

We may use and disclose your protected health information to provide, coordinate, or manage your audiological treatment and any related services. We may also disclose your protected health information to other third party providers involved in your audiological/health care. For example, your protected health information may be provided to a physician or other audiological/health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other audiological/health care provider has the necessary information to diagnose or treat you.

2. Payment

We may use and disclose your protected health information so that the treatment and health care services you receive may be billed to you, your insurance company, a government program, or third party payors. This may include certain activities that your health insurance plan may undertake before it approves or pays for the audiological/health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may provide your health plan with medical information about the audiological/health care services Midland Hearing Associates rendered to you for reimbursement purposes.

3. Audiological/Health Care Operations

We may use and disclose your protected health information for audiological/health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to audiologists, physicians, nurses, technicians, medical students, and other personnel for educational and learning purposes.

4. Treatment Communications

We may provide treatment communications concerning treatment alternatives or other health related products or services. For communications for which we or a business associate may receive financial remuneration in exchange for making the communication, we must obtain written authorization unless the communication is made face-to-face and/or involving promotional gifts of nominal value. If you do not wish to receive these communications please submit a written request to our Privacy Officer, Melissa Kednocker, Midland Hearing Associates, One Wellness Blvd. Suite 108, Irmo, SC 29063.

5. Fundraising Activities
We may use or disclose your demographic information and dates of services provided to you, as necessary, in order to contact you for fundraising activities supported by Midland Hearing Associates. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to our Privacy Officer, Melissa Kednocker, Midland Hearing Associates, One Wellness Blvd. Suite 108, Irmo, SC 29063.

6. Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. Also, for example, if you are brought into this office and are unable to communicate normally with your clinician for some reason, we may find it is in your best interest to give your hearing instrument and other supplies to the friend or relative who brought you in for treatment. We may also use and disclose protected health information to notify such persons of your location, general condition, or death. We also may coordinate with disaster relief agencies to make this type of notification. We also may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up your hearing instruments, supplies, records, or other things that contain protected health information about you.

7. Required by Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. **8. Public Health**
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

9. Business Associates
We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. To protect your health information, however, we require the business associate to appropriately safeguard your information.

10. Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

11. Health Oversight
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies
seeking this information include government agencies that oversee the audiological/health care system, government benefit programs, other government regulatory programs and civil rights laws.

12. Abuse or Neglect
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

13. Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

14. Legal Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.

15. Law Enforcement
We may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

16. Coroners, Funeral Directors, and Organ Donation
We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out its duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
17. Research
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
18. Serious Threat to Health or Safety
Consistent with applicable federal and state laws, we may disclose your protected health information to prevent or lessen a serious threat to your health and safety or to the health and safety of another person or the public.
19. Military Activity and National Security
If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your protected health information to authorized officials so they may carry out their legal duties under the law.
20. Workers' Compensation
We may disclose your protected health information as authorized for workers' compensation or other similar programs that provide benefits for a work-related illness.
21. For Data Breach Notification Purposes
We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.
22. Required Uses and Disclosures
Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.
SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION
Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.
USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION
The following uses and disclosures will be made only with your written authorization:
1. Uses and disclosures of protected health information for marketing purposes for which we or a business associate may receive remuneration; and
2. Disclosures that constitute a sale of protected health information.
Other uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that Midland Hearing Associates has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.
YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION
The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.
1. Right to be Notified if there is a Breach of Your Protected Health information
You have the right to be notified upon a breach of any of your unsecured protected health information.
2. Right to Inspect and Copy -You may inspect and obtain a copy of your protected health information that is contained in your medical and billing records and any other records that Midland Hearing Associates uses for making decisions about you. To inspect and copy your medical information, you must submit a written request to our Privacy Officer, Melissa Kednocker, Midland Hearing Associates, One Wellness Blvd. Suite 108, Irmo, SC 29063. If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with you request. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil,

criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our Privacy Officer, Melissa Kednocker, at (803) 765-1919 ext. 1 or betterhearing@midlandhearing.com if you have questions about access to your medical record.

3. Right to Request Restrictions- You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. To request a restriction on who may have access to your protected health information, you must submit a written request to our Privacy Officer, Melissa Kednocker, Midland Hearing Associates, One Wellness Blvd. Suite 108, Irmo, SC 29063. Your request must state the specific restriction requested and to whom you want the restriction to apply. Midland Hearing Associates is not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or audiological/health care operation purposes and such information you wish to restrict pertains solely to a audiological/health care item or service for which you have paid us "out-of-pocket" in full. If we believe it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

4. Right to Request Confidential Communication- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. You must request this by submitting a written request to our Privacy Officer, Melissa Kednocker, Midland Hearing Associates, One Wellness Blvd. Suite 108, Irmo, SC 29063.

5. Right to Request Amendment -You may request an amendment of your protected health information contained in your medical and billing records and any other records that Midland Hearing Associates uses for making decisions about you, for as long as we maintain the protected health information. You must request for an amendment by submitting a written request to our Privacy Officer, Melissa Kednocker, Midland Hearing Associates, One Wellness Blvd. Suite 108, Irmo, SC 29063, and provide the reason(s) that support your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

6. Right to an Accounting of Disclosures -You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. You must request for an accounting of disclosures by submitting a written request to our Privacy Officer, Melissa Kednocker, Midland Hearing Associates, One Wellness Blvd. Suite 108, Irmo, SC 29063, and provide the reason(s) that support your request.

7. Right to Obtain a Paper Copy of this Notice -You have the right to receive a paper copy of this Notice even if you have agreed to receive this notice electronically. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this Notice, you can contact our Privacy Officer, Melissa Kednocker, at (803) 765-1919 ext. 1 or betterhearing@midlandhearing.com. You may also obtain a copy of this Notice at www.midlandhearing.com.

COMPLAINTS OR QUESTIONS -If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. If you have a question about this Notice or wish to file a complaint with us, please contact our Privacy Officer, Melissa Kednocker, at (803) 765-1919 ext. 1 or betterhearing@midlandhearing.com or the Corporate Privacy Officer at the address listed below. All complaints must be submitted in writing. Midland Hearing Associates will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE -We reserve the right to change this Notice at any time. The new Notice will be effective for all health information we already have about you as well as any information we receive in the future. You can also obtain a revised Notice at www.midlandhearing.com or by contacting our Privacy Officer, Melissa Keddnocker, Midland Hearing Associates, One Wellness Blvd. Suite 108, Irmo, SC 29063. Midland Hearing Associates Attn: Corporate Privacy Officer

This Notice is effective as of April, 2013.

PATIENT GUIDE

Midland Hearing Associates wants you to be aware of the Federal Government rules and regulations that are in place to protect your health information. Midland Hearing Associates is committed to helping you understand these rules and regulation so that we can most effectively treat you.

Midland Hearing Associates provides documents that tell you how information that may identify you and that relates to your audiological/health care will be used. Some of these documents must be signed by you to show you received and understand them and to enable the highest level of care by Midland Hearing Associates.
This pamphlet provides an overview of the documents you will receive from Midland Hearing Associates.

Notice of Privacy Practices
The Notice of Privacy Practices is a lengthy document that goes into detail to fully inform you about how your health information is used. In a nutshell, the Notice of Privacy Practices covers the following topics:

- How Midland Hearing Associates manages and protects your health information.
- How you can restrict certain uses and disclosures of your protected health information
- Your rights in requesting information about your protected health information; and
- Contact information if you have any questions or concerns regarding your protected health information.
- Midland Hearing Associates requests that you sign an acknowledgement that you received the Notice of Privacy Practices.

Authorization to Use and Disclosure
To assist Midland Hearing Associates in providing the best care possible and to communicate with those close to you and other health professionals that may be treating you, Midland Hearing Associates provides you a form to let us know who we can share your health information with.

Marketing Authorization
The marketing authorization form authorizes Midland Hearing Associates to contact you with various product and/or treatment options related to your audiological/health care. Midland Hearing Associates may receive compensation for these communications. The authorization form gives you the option of either:

- Authorizing all marketing communications.
- Requiring authorization for any one marketing communication.
- Prohibiting any marketing communication.

Questions/Comments
Please do not hesitate to ask us any questions you may have about your protected health information. You may contact our Privacy Officer, Melissa Kednocker, at (803) 765-1919 ext. 1 or betterhearing@midlandhearing.com.

Comprehensive Case History Form

Patient's Name: _____ Date: _____

Date of Birth: _____ Gender: Male or Female Primary Language: _____

Status Marital: Single Married Divorced Widowed

Current Employment: Full-time Part-time Retired Unemployed

Current Employer: _____ Position: _____

Do you currently use tobacco? Yes No

If yes, what do you smoke: Cigarettes Cigars Pipe Smokeless

If yes, amount per day: _____

Do you currently drink alcoholic beverages? Yes No

If yes, how often: Daily Weekly Monthly Occasionally

Audiologic History

Do you experience hearing loss? Yes No If so, which ear? Left Right Both

If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden

When did you first notice your hearing loss? _____

What do you think caused your hearing loss?_____

Have you ever had a hearing test? Yes No If so, when? _____

Which ear do you use to talk on the phone? Right Left

Have you ever worn or tried a hearing aid? Yes No If so, which ear? Left Right Both

What type and/or style of hearing aid: _____

Please describe your experience: _____

Do you still experience any of the following with your current hearing aid (please check all that apply):

○ Some sounds are too loud	○ Trouble understanding in quiet	○ Trouble understanding in noise
○ Sounds are too soft	○ Wind noise	○ Do not like appearance of aid
○ Pain	○ Trouble using telephone	○ Do not like sound of own voice
○ Sounds are tinny or metallic	○ Feedback or whistling	○ Cannot tell direction of sound
○ Cleaning hearing aid	○ Changing battery	○ Battery life
○ Naturalness of sound	○ Repair issues	○ Other: _____

Please check all medical conditions that apply:

____ Developmental Disorder/Delays *If Checked, please explain:* _____

____ Dizziness or Unsteadiness *If Checked, is it accompanied by: Vomiting Nausea Ear Noises*

____ Ear Deformity *If Checked, Right Ear Left Ear Both Ears*

____ Ear Drainage *If checked, Right Ear Left Ear Both Ears*

____ Ear Pain *If checked, Right Ear Left Ear Both Ears*

____ Family History of Hearing Loss *If checked, who?* _____

____ History of Ear Infections *If checked, Right Ear Left Ear Both Ears*

____ History of Ear Wax Buildup

____ History of Noise Exposure *If checked, please describe?* _____

____ Previous Ear Surgery *If checked, Right Ear Left Ear Both Ears*

____ Tinnitus/Ringing/Noises in ears *If checked, Right Ear Left Ear Both Ears*

____ Other: *Please describe:* _____

Please answer the following questions:

Does a hearing problem cause you to feel embarrassed when you meet new people? Yes Sometimes No

Does a hearing problem cause you to feel frustrated when talking to members of your family? Yes Sometimes No

Do you have difficulty when someone speaks in a whisper? Yes Sometimes No

Do you feel that any difficulty with your hearing limits your social life? Yes Sometimes No

Does a hearing problem cause you difficulty when in a restaurant with family or friends? Yes Sometimes No

Does a hearing problem cause you to attend religious services less often? Yes Sometimes No

Does a hearing problem cause you difficulty when listening to TV or radio? Yes Sometimes No

Medical History

Any other illnesses, surgeries or injuries since birth and their dates(s) of occurrence:_____

_____

_____

Allergies (food, medications, plastics, etc.) _____

Have you experienced any of the following major medical conditions (please check all that apply):

___ Aids/HIV	___ Diphtheria	___ High Blood Pressure	___ Mumps
___ Appetite Change	___ Encephalitis	___ High Fevers	___ Scarlet Fever
___ Arthritis	___ Fatigue	___ Influenza	___ Stroke
___ Blood Disorders	___ Genetic Disorders___	Malaise	___ Tonsillitis
___ Cancer	___ Headaches	___ Malaria	___ Typhoid
___ Chicken Pox	___ Head Injury	___ Measles	___ Vascular Problems
___ Diabetes	___ Heart Problems	___ Meningitis	___ Other:_____

Current Medications (please list drug name, dosage, frequency and route): _____

_____

_____

_____

Please mark all medical symptoms that apply:

- Eye problems (such as blurred vision, pain): Yes No
- Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain): Yes No
- Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations): Yes No
- Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma): Yes No
- Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness): Yes No
- Psychiatric Issues (such as depression, anxiety, compulsions): Yes No

Comments Related to Review of Symptoms: