

Dear Patient,

Welcome to Internal Medicine Associates of Irving. We are so pleased to have you as our patient. Our practice is committed to providing the best treatment to our patients.

We are a five-partner group of board certified physicians in Internal Medicine. Internal Medicine Associates of Irving is part of HealthTexas, a non-profit physician organization affiliated with the Baylor Health Care System. Internists are specialists with extensive training in the diagnosis and treatment of medical problems in adults. As your internist, we can provide you with your annual wellness exam, screen for diseases such as breast, prostate and colon cancer, as well as determine your risk for cardiovascular disease. In addition to treatment of acute illnesses such as the flu, we also manage chronic illnesses like asthma, high blood pressure, and elevated cholesterol. We will coordinate care with other specialists such as dermatologists and neurologists when additional care is needed. We provide quality care to our patients, in a friendly and professional environment. Our office has full laboratory services, to help us manage your health needs at one location. Radiology and bone densitometry services are also available on site. We also embrace an "open access policy" at our clinic, which means we reserve same day appointments for established patients who are sick "today." We don't think you should have to wait a week for a sore throat or fever!

The following pages contain information about our office policies and procedures. Please review them and feel free to ask us any questions you may have.

Sincerely,

The Physicians of Internal Medicine Associates of Irving

## **Electronic Communications to Patients**

Baylor Office EHR is a joint effort of HealthTexas Physician Network physicians and other physicians aligned with Baylor Health Care System to fully support an electronic patient care experience through implementation of a common electronic health record platform. HealthTexas Physician Network (“HTPN”) is pleased to offer Baylor Office EHR as a convenience to communicate electronically with you under the conditions and terms outlined below.

### Use of Electronic Communication from HTPN to the Patient

Please check the appropriate box below:

Yes, I want HTPN to communicate my information with me through a secure system that is designed to keep your information safe. You will be notified via email when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. You will need to make note of the password to access any future information.

Please enter in the space below the e-mail address you want to use to receive the notification that there is information awaiting your review:

**E-mail address:** \_\_\_\_\_.

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

No, I do not want HTPN to use electronic communication as a way to communicate my information to me.

### HTPN E-mail Guidelines

- At this time, HTPN can only send e-mails *to* patients. Currently, HTPN is not able to *accept* patient e-mails.
- All e-mail you receive from HTPN is sent under the name and e-mail account of DFW Centricity.
- The patient is responsible to notify HTPN promptly of any changes to his/her e-mail address.
- All of HTPN’s electronic communications to you are recorded in your medical record. Those who have access to your medical record also have access to the e-mail messages sent to you.

### Confidentiality and Privacy

- If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information.
- HTPN will not share your e-mail address with anyone unauthorized to view your medical record.

### Consent and Agreement

*I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from HTPN. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

Practice Name, Address,  
City, State ZIP

## HealthTexas Provider Network

FOR OFFICE USE ONLY

Acct # \_\_\_\_\_

### Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Date**

### Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Date**

## Office Policies

It is our goal to provide all of our patients with the best service possible. We know that your time is valuable, and we respect that. Below is a copy of our office policies, please take the time to read them and become familiar with them. We appreciate your consideration in complying with these policies, as adhering to them will allow us to better care for your needs.

**HOURS:** We are open Monday through Friday from 7:30am to 4:30pm. We are closed on Saturday and Sunday. You can contact a physician after hours for urgent needs by calling our answering service at 972-251-2388. All physicians of Internal Medicine Associates of Irving share call on a rotational basis.

**APPOINTMENTS:** We see patients by appointment only. Any patient arriving 15 minutes or more late for an appointment will be asked to either reschedule or to wait until the physician can work you in. This is to help keep patients seen as close to their scheduled appointment time as possible. Due to the heavy volume of patients seen, if you cannot keep your appointment, you will need to reschedule your appointment 24 hours in advance. This will allow us to schedule a patient on our waiting list sooner. If any appointment is missed and proper notice was not given, a \$35.00 charge may be billed to your account. This charge is not payable by your insurance company. If multiple appoints are missed and we identify a problem with you keeping appointments, we will not be able to provide care for you at this office.

**WALK-INS:** We see patients by appointment only. If you have an urgent matter, please call the clinic to be worked in for a same day appointment. Any patient who arrives without an appointment will be triaged by one of our clinical staff to decide the correct course of action. Only urgent issues will be addressed at your visit. If you are having other, non-urgent concerns, you will need to make another appointment to address them.

**FEES:** All co-pays and deductibles are due at the time of your visit. The front desk will let you know if your insurance plan is accepted. If we are on your medical insurance, we will gladly file the claim for you. If we are not, a copy of your bill will be given to you, to assist you in filing the claim. Our billing office is located in Dallas and can be reached at 972-664-2500 if you need assistance.

**REFERRALS:** If you need a referral from a physician, please allow 3 days for it to be completed. The physician's clinical staff handles all referrals.

- LAB:** Lab work is drawn from 7:30am to 4:30pm every weekday at our on-site lab facility. If you have an appointment for labs only, please check in at the front desk and they will direct you to the lab. All labs will be sent to a facility on your healthcare plan. Some tests may take up to 10 days to receive results back. Please call the office if you have not received a report in 10 days.
- REFILLS:** Prescriptions are filled during office hours only. Charts are not available at night for the physician to review. If you need forms or written prescriptions filled out by the physician, please call the office 72 hours in advance of needing the refills to avoid a lengthy wait time. For refills through your pharmacy, please have them fax requests to 972-251-2390.
- SAMPLES:** The physician may give samples at the time of your visit in order for you to try a new medication. We do not routinely provide samples for your standard medications, but will gladly call in refills for you.
- FORMS:** There is a \$25 charge for the completion of FMLA, disability and other forms. Since insurance companies do not cover this service, this charge is your responsibility. Payment is due at the time the forms or requests are dropped off at the clinic.

I have read and received a copy of the office policies for Internal Medicine Associates of Irving.

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Signature

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Date

# Internal Medicine Associates of Irving

## PATIENT INFORMATION

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Gender \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Name of legal guardian (legal documentation required) if patient is a minor \_\_\_\_\_

Street Address \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_ ) ( ) \_\_\_\_\_ - \_\_\_\_\_  
Home phone Work phone Cell phone

Referred by: \_\_\_\_\_

Employment Status: Full-time / Part-time / Not Employed / Self / Retired / Active Duty (circle one)

Student Status: Full-time / Part-time / Not a Student (circle one) Driver License # \_\_\_\_\_

Guarantor/patient employer \_\_\_\_\_ Employer phone number ( ) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Emergency phone number ( ) \_\_\_\_\_ - \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Policyholder \_\_\_\_\_

Policyholder's Sex \_\_\_\_\_ Policyholder's DOB \_\_\_\_\_ Policyholder's SSN \_\_\_\_\_

Patient's Relationship to Policyholder \_\_\_\_\_ Policyholder's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Effective Date \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policyholder's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Type: Is this insurance coverage obtained thru an employer? Yes No (circle one)

Patient policy ID# if different from policyholder's \_\_\_\_\_ Group # \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Policyholder \_\_\_\_\_

Policyholder's Sex \_\_\_\_\_ Policyholder's DOB \_\_\_\_\_ Policyholder's SSN \_\_\_\_\_

Patient's Relationship to Policyholder \_\_\_\_\_ Policyholder's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Effective Date \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policyholder's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Type: Is this insurance coverage obtained thru an employer? Yes No (circle one)

Patient policy ID# if different from policyholder's \_\_\_\_\_ Group # \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## HEALTHTEXAS PROVIDER NETWORK NOTICE OF HEALTH INFORMATION 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.

#### **Understanding Your Health Record/ Information**

This notice describes the practices of HealthTexas Provider Network (HTPN) and that of its physicians<sup>1</sup> with respect to your protected health information created while you are a patient at HTPN. HTPN physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, HTPN physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at HTPN. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at HTPN.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

#### **Your Health Information Rights**

Although your health record is the physical property of HTPN, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with

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<sup>1</sup> Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

your care and as provided by law. However, we are not required by law to agree to a requested restriction;

- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Compliance Officer at HealthTexas Provider Network, 8080 North Central Expressway, Suite 1700, LB 83, Dallas, TX, 75206.

#### **Our Responsibilities**

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;

- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at HTPN. The revised notice will also be posted at HTPN offices and on the Baylor Health Care System web page at [www.baylorhealth.edu](http://www.baylorhealth.edu); and
- We will not use or disclose your health information without your written authorization, except as described in this notice.

#### **Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

*We will use your health information for treatment.*

**For example:** We may disclose medical information about you to

doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at HTPN. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at HTPN.

*We will use your health information for payment.*

**For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

*We will use your health information for regular health care operations.*

**For example:** We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

*We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.*

**Business associates:** There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

**Funeral directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

**Organ procurement organizations:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Communications for treatment and health care operations:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Fundraising:** We may contact you as part of a fundraising effort.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Worker's compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Public health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Abuse, neglect or domestic violence:** As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

**Judicial, administrative and law enforcement purposes:** Consistent with applicable law, we may disclose health information about you for judicial,

administrative and law enforcement purposes.

**Required or allowed by law:** We will disclose medical information about you when required or allowed to do so by federal, state or local law.

### **For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the Baylor Health Care System Office of HIPAA Compliance at 1-866-245-0815.

If you believe your privacy rights have been violated, you can file a complaint with the Baylor Health Care System Office of HIPAA Compliance or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

**EFFECTIVE DATE: 02/01/06**  
**VERSION: 2**

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



**ACKNOWLEDGMENT OF THE RECEIPT OF  
HEALTHTEXAS PROVIDER NETWORK'S (HTPN) NOTICE OF HEALTH INFORMATION  
PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians<sup>1</sup> may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's *Notice of Health Information Practices*.**

\_\_\_\_\_  
(Signature of Patient or Legal Representative)

\_\_\_\_\_  
(Date)

February 1, 2006  
(Effective Date of Notice)

<sup>1</sup>Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

# Insurance Waiver

Internal Medicine Associates of Irving  
2021 N MacArthur Blvd Irving TX 75061

**Patient Name:** \_\_\_\_\_ **ID #** \_\_\_\_\_ **DOS** \_\_\_\_\_

## PROVIDER STATEMENT:

Based on the information that you have provided to us, we believe that it is likely that your insurance company \_\_\_\_\_ will limit or deny coverage for the following items or services:

ITEM(S) / SERVICE (S)	ESTIMATED CHARGE (S)

## REASON CODES (check all that apply)

\_\_\_\_\_ Patient did not have insurance card, patient agrees to call information back to our phone number \_\_\_\_\_ by \_\_\_\_\_ or will be billed as self pay.  
(Phone #) (Date)

\_\_\_\_\_ Our Facility/Provider is not a contracted facility/provider for the above listed service(s).

\_\_\_\_\_ Your insurance company may determine that the following service is not a covered benefit for the diagnosis that was provided to use by your physician:  
\_\_\_\_\_.

\_\_\_\_\_ You have reached the maximum benefit provided by your insurance company for this service, according to your insurance carrier. Certain frequency limitations may apply.

\_\_\_\_\_ Your insurance company does not usually provide for screening or research testing.

\_\_\_\_\_ Patient understands that the physician from which (s)he will be receiving health services is not the PCP of record. Futhermore, patient understands that the insurance company will not pay for any health services rendered by a provider who is not the members' current PCP of record.

\_\_\_\_\_ Other:  
(explain) \_\_\_\_\_

## BENEFICIARY'S STATEMENT:

Yes. I want to receive these items or services. I understand that my insurance company may not/will not pay. I understand that I am personally and fully responsible for the payment.

No. I have decided not to receive these items or services.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_ Patient Identifier #: \_\_\_\_\_

## Patient Preference Regarding Communication of Health Information

### I. Who to Contact

I hereby give permission to Internal Medicine Associates of Irving to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

\_\_\_\_\_ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

### II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:
<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call-back number only

<input type="checkbox"/> Written Communication
<input type="checkbox"/> OK to mail to my home address _____
_____
<input type="checkbox"/> OK to mail to my work/office address _____
_____
<input type="checkbox"/> OK to fax to this number _____
_____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

**INTERNAL MEDICINE ASSOCIATES OF IRVING  
HEALTH HISTORY**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete this questionnaire. This form is intended to supplement your interview and is entirely confidential. Thank you.

**Occupation:** \_\_\_\_\_

**Drug Allergies & Reactions:** \_\_\_\_\_

**Medications** (include vitamins, over-the-counter meds, oral contraceptives): \_\_\_\_\_

**Social Habits:** Check and describe all that apply.

\_\_\_\_\_ Caffeine \_\_\_\_\_ Tobacco \_\_\_\_\_

\_\_\_\_\_ Alcohol \_\_\_\_\_ Drugs \_\_\_\_\_

\_\_\_\_\_ Exercise \_\_\_\_\_ Diet \_\_\_\_\_

\_\_\_\_\_ Sexually Active \_\_\_\_\_

**Women:** Date of last period \_\_\_\_\_ Menstrual History \_\_\_\_\_

# of pregnancies \_\_\_\_\_ Contraceptive Method \_\_\_\_\_

Any problems? \_\_\_\_\_

**Medical Illnesses** (e.g. diabetes, cancer, lung/heart/stomach/kidney/liver disease, nervous or psychiatric disorders): \_\_\_\_\_

**Surgeries/Hospitalization** (e.g. appendix, tonsils, hysterectomy, vasectomy, etc.): \_\_\_\_\_

**Family History:**

Living? Age/age at Death Describe any health problem/cause of death

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers/Sisters \_\_\_\_\_

Please list any "family" illnesses \_\_\_\_\_

**Health Maintenance:** Please indicate the year you last had the following:

TB Skin Test \_\_\_\_\_ Pap Smear \_\_\_\_\_

Eye Exam \_\_\_\_\_ Bone Density \_\_\_\_\_

Sig/Colonoscopy \_\_\_\_\_ Cholesterol \_\_\_\_\_

Mammogram \_\_\_\_\_ PSA \_\_\_\_\_

Dental Exam \_\_\_\_\_

**Immunizations:**

Tetanus \_\_\_\_\_ Pneumonax \_\_\_\_\_

Influenza \_\_\_\_\_ Hepatitis A/B \_\_\_\_\_

Other \_\_\_\_\_

Please check Symptoms you currently have or suffer from on a chronic basis:

Name \_\_\_\_\_

Date \_\_\_\_\_

X GENERAL

- Chills/Sweats
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness/Poor Memory
- Headache
- Difficulty Sleeping
- Loss/Gain of weight
- Nervousness/Anxiety
- Fatigue
- Poor Concentration
- Temperature intolerance

X MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms/Hands
- Legs/Feet
- Back/Hips
- Neck/Shoulders

X SKIN

- Bruise easily
- Hives
- Itching/dryness
- Changes in moles
- Rash
- Sore that won't heal
- Nail changes

X EYE,EAR,NOSE,THROAT

- Vision disturbances
- Difficulty swallowing
- Earache
- Ear drainage
- Hay fever/allergies
- Hoarseness
- Loss of hearing
- Nosebleeds
- Sinus problems
- Dental problems
- Bleeding gums

X GASTROINTESTINAL

- Poor appetite
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive gas
- Excessive thirst
- Hemorrhoids
- Indigestion
- Nausea/Vomiting
- Black/Bloody Stools
- Stomach pain

X CARDIOVASCULAR

- Chest pain/discomfort
- High Blood Pressure
- Irregular Heart Beat
- Palpitations
- Poor circulation
- Swelling of ankles
- Varicose veins
- Exercise intolerance

X PULMONARY

- Persistent cough
- Cough up blood
- Shortness of breath
- Wheezing
- Night Sweats

X GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination
- Frequent infection
- Kidney stone

X MEN ONLY

- Breast lump
- Erection difficulties
- Problems with sex life
- Lump in testicles
- Penis discharge
- Sore on penis
- Urinary dribbling
- Weak urinary flow

X WOMEN ONLY

- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Breast pain
- Menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Problems with sex life
- Vaginal discharge
- Vaginal itching
- Premenstrual symptoms

X OTHER