



Thomas M. Stanley, M.D.  
J. Michael Hemphill, M.D.  
Joel A. Greenberg, M.D.  
Eric M. Pearlman, M.D.  
Katherine Moretz, M.D.  
Jessica Carter, M.D.

## WELCOME

You have an appointment with Savannah Neurology Specialists, P.C. on: \_\_\_\_\_  
at \_\_\_\_\_.

The following paperwork is enclosed and **must** be completed prior to arrival at the office:

Patient information  
Medical History Form  
Private Policy Form

A complete neurological exam may take up to two (2) hours to complete. Therefore, please be prepared to spend a considerable amount of time in our office for the process. Feel free to bring books, magazines, and/or needlework to help occupy your time.

**If you are unable to keep your appointment please give us 24-hour notice.**

We file insurance as a **courtesy** to patients, however we expect the following:

- New patients must bring their insurance cards and picture ID is required.
- Patients need to bring any referrals necessary to process insurance. Failure to do so may result in rescheduling your appointment.
- Patients being seen for follow-up visits will be responsible for having their referrals current. Failure to do so may result in rescheduling your appointment.
- Co-pays and deductibles will be collected at each visit.

Please bring, or have your referring physician forward to us your current medications, all medical records, diagnostic testing, EEG reports, and laboratory findings.  
Please bring a copy of your X-rays and/or MRI at the time of your visit.

We look forward to having you as a patient. If you have any questions regarding the enclosed information or office procedures, please do not hesitate to call us at (912) 353-3333.

**Please do not mail the packet back.** Bring the completed paperwork on the day of your appointment.

**Accident Questionnaire/Other Insurance**

Account#: \_\_\_\_\_

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

Address: \_\_\_\_\_

\_\_\_\_\_

Insured Name: \_\_\_\_\_

Policy#: \_\_\_\_\_

Group#: \_\_\_\_\_

Date of Service: \_\_\_\_\_

**Was this accident related?**     yes     no                      **Date of accident:** \_\_\_\_\_

**Was this work related?**         yes     no                      **Date of accident:** \_\_\_\_\_

**Describe in detail why you are seeing the doctor today:**

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

**Will this claim be filed with any other insurance such as auto, homeowners or business liability, etc?**     yes     no

Name of insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Insured: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Do you have any other insurance other than what you have listed above that you would like to be filed on this claim?**     yes     no

If yes, please list information below.

Name of insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

Insured: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

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

\_\_\_\_\_  
Date



**Patient Registration** (Please print clearly)

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
SSN \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_  
Address \_\_\_\_\_ Apt. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Work # \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_

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**If patient is a minor or dependent, please complete the following information:**

Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

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**Primary Insurance (A copy of your insurance card is required)**

Insurance \_\_\_\_\_  
ID \_\_\_\_\_ Group \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer Name \_\_\_\_\_

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**Secondary Insurance (A copy of your insurance card is required)**

Insurance \_\_\_\_\_  
ID \_\_\_\_\_ Group \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer Name \_\_\_\_\_

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**Emergency Contact**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

**Savannah Neurology Specialist, PC**

**Physician Practice Financial Policy and Release of Information**

The following is a statement of our Financial Policy for services provided within our office and do not apply to any testing or diagnosis procedure performed outside of this physician practice. We require you to read and sign this document prior to treatment by this facility.

**Patient Responsibility**

All professional services rendered are charged to the patient and are due at the time of the service. As a courtesy this practice will file your claim with your insurance carrier however, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.

Initial \_\_\_\_\_

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs, and other outpatient procedures may have higher co-payment or fall under the deductible. It is the patient's responsibility to understand their insurance coverage and to notify us of any changes.

Initial \_\_\_\_\_

When you receive a statement from Savannah Neurology Specialist PC, you are required to pay the balance due upon receipt of the statement. If for some reason you do not agree with the balance due amount, you are to contact a billing representative at the phone number noted on the statement. DO NOT IGNORE THE BILL, as it may result in placing the balance with an outside agency for recovery.

Initial \_\_\_\_\_

**Authorization for Treatment and to Release Information**

The signature below serves as authorization for medical treatment by the physician, Physician's assistant, nurse practitioner, or nurse for the named patient. It also provides Authorization for Savannah Neurology Specialist PC to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payer representatives in order to process health care claims incurred at this office or utilization review or quality assurance. This authorization also serves as permission to obtain a copy of your complete medical record from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining the medical records. I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by written withdrawal.

Initial \_\_\_\_\_

**Appointment of Representative and Authorization to Appeal**

I appoint Savannah Neurology Specialist PC as my representative to appeal any claims on my behalf.

Initial \_\_\_\_\_

I understand that I am financially responsible to Savannah Neurology Specialist PC for any balance not covered by the insurance carrier.

**ASSIGNMENT OF BENEFITS**

I hereby assign and authorize my insurance benefits to be paid directly to Savannah Neurology Specialist PC.

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Patient Name (please print)

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Signature of Patient or Responsible Party

Date

**Savannah Neurology Specialists**

912-353-3333

**ACKNOWLEDGEMENT OF THE PRIVACY ACT OF 2007  
PATIENT RECORD OF DISCLOSURE**

In general the HIPPA privacy rules give individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home via mail or fax.

You may also acknowledge that we may leave a message with, discuss you treatment, appointments or other scheduling that may occur or provide other information as necessary with the following family, friends or personal representatives. **I understand that Savannah Neurology Specialists will refuse to discuss my information with anyone not listed below, except in an emergency.** I also understand that this consent does not apply to medical providers in the treatment of my care.

PLEASE PRINT

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

I have received a copy of the Savannah Neurology Specialists "Notice of Privacy Practices" which details how my personal health information may be used and disclosed as permitted under Federal and State law. I have read and understand the contents of the notice.

\_\_\_\_\_  
**Print Patient's Name**

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

\_\_\_\_\_  
**Signature**

**If not signed by the patient, please indicate the relationship of the person signing to the patient.**

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Witness

**If a patient/representative refuses to sign this acknowledgement of Receipt, please document why including the date and time.**

\_\_\_\_\_  
**Presented and Refused Reason**

\_\_\_\_\_  
**Name/Title/Date/Time**

# NOTICE OF PRIVACY POLICIES FOR Savannah Neurology Specialists, P.C.

**This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

## Introduction

At Savannah Neurology Specialists, P.C., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

## Understanding Your Health Record/Information

Each time you visit Savannah Neurology Specialists, P.C. a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others

## Your Health Information Rights

Although your health record is the physical property of Savannah Neurology Specialists, P.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record.
- Amend your health record.
- Obtain an accounting of disclosures of your health information: To do this, please contact Savannah Neurology Specialists, P.C.'s Privacy Officer. This information will be provided to you within 30 days.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose your health information.

## Our Responsibilities

Savannah Neurology Specialists, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice about our privacy practices,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We will not use or disclose your health information without your authorization, except as described in this notice. To revoke your authorization, please put your request in writing to Savannah Neurology Specialists, P.C.

## For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at (912) 353-3333.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

## Office for Civil Rights

U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, D.C. 20201

### Examples of Disclosures for Treatment, Payment and Health Operations

*We will use your health information for treatment.*

**For example:** Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your other physicians or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

*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 operations.*

**For example:** Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes 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 healthcare and service we provide.

**Directory:** Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

**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.

**Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**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 ensure 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.

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

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

**Workers compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers 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.

**Law enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**SAVANNAH NEUROLOGY SPECIALISTS, P.C.**  
912-353-3333/ 912-790-4840 FAX

**PEDIATRIC MEDICAL HISTORY**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON COMPLETING FORM \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

WHY ARE YOU HERE? DESCRIBE SYMPTOMS \_\_\_\_\_

\_\_\_\_\_

WHEN DID THE PROBLEM START? \_\_\_\_\_

GETTING BETTER/WORSE? \_\_\_\_\_

HAS YOUR CHILD SEEN ANOTHER PEDIATRICIAN FOR THIS, OR A SIMILAR CONDITION?  
WHOM? WHEN? \_\_\_\_\_

\_\_\_\_\_

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN AND THE NAMES/SPECIALTIES FOR ANY  
OTHER PHYSICIAN PATIENT HAS SEEN.

\_\_\_\_\_

\_\_\_\_\_

HAS DIAGNOSTIC TESTING BEEN DONE FOR THIS CONDITION? WHERE? WHEN?  
(X-RAYS, MRI, CT SCAN, LABWORK, EMG, EEG)

\_\_\_\_\_

\_\_\_\_\_

**\*When available, please be sure to bring any and all pertinent medical records, diagnostic testing reports, lab results, and/or actual films to your appointment. If you choose, you may hand deliver records at time of appointment OR have records faxed or mailed at contact address above.**

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**PRENATAL CARE/DELIVERY**

HOW OLD WAS MOTHER DURING DELIVERY \_\_\_\_\_ BIRTH ORDER? (1<sup>ST</sup>, 2<sup>ND</sup> .....)  
NUMBER OF PREGNANCIES \_\_\_\_\_ LIVE BIRTHS \_\_\_\_\_ MISCARRIAGES/ABORTIONS \_\_\_\_\_  
ANY COMPLICATION WITH PREGNANCY OR DELIVERY? \_\_\_\_\_

MEDICATIONS DURING PREGNANCY? \_\_\_\_\_

ANY DRUG OR ALCOHOL USE DURING PREGNANCY? \_\_\_\_\_ HOW LONG WAS LABOR? \_\_\_\_\_  
WAS MEDICATION USED TO INDUCE LABOR? \_\_\_\_\_

WAS BABY EARLY? LATE? \_\_\_\_\_ # OF WEEKS \_\_\_\_\_

BREACH BIRTH? \_\_\_\_\_ C-SECTION \_\_\_\_\_ FORCEPS USED \_\_\_\_\_ VACUUM SUCTION USED? \_\_\_\_\_

MOTHER GIVEN ANESTHESIA? \_\_\_\_\_ GENERAL OR EPIDURAL? \_\_\_\_\_

WAS THERE A DELAY IN BREATHING OR CRYING? \_\_\_\_\_ DID THE BABY NEED ASSISTANCE WITH  
BREATHING? \_\_\_\_\_? WAS THE BABY IN THE SPECIAL CARE NURSERY? \_\_\_\_\_

WHAT HOSPITAL WAS THE BABY BORN IN? \_\_\_\_\_

HOW LONG WAS THE BABY HOSPITALIZED? \_\_\_\_\_

BIRTH WEIGHT? \_\_\_\_\_ APGAR SCORES \_\_\_\_\_

WAS THE BABY A POOR FEEDER? \_\_\_\_\_

**DEVELOPMENTAL MILESTONES / MOTOR SKILLS**

PLEASE INDICATE THE APPROXIMATE AGE YOUR CHILD DID THE FOLLOWING:

SMILE \_\_\_\_\_ SAY MA-MA & DA-DA \_\_\_\_\_ WAVE BYE-BYE \_\_\_\_\_

DRINK FROM A CUP WITHOUT A LID \_\_\_\_\_ USE BOTH HANDS FREELY \_\_\_\_\_

FINGER FEED HIMSELF \_\_\_\_\_ USE FORK \_\_\_\_\_ SAY TWO WORD SENTENCES \_\_\_\_\_

ROLL OVER \_\_\_\_\_ SIT ALONE \_\_\_\_\_ CRAWL \_\_\_\_\_

WALK WITH ASSISTANCE \_\_\_\_\_ WALK ALONE \_\_\_\_\_

IS CHILD'S DEVELOPMENT SIMILAR TO THAT OF SIBLINGS? \_\_\_\_\_

DO YOU FEEL THAT YOUR CHILD IS ABLE TO DO THE SAME SKILLS AS OTHER CHILDREN THEIR  
AGE? \_\_\_\_\_



**PERSONAL / SOCIAL HISTORY**

**WHO LIVES IN THE HOME WITH THE CHILD? PLEASE LIST RELATIONSHIP AND AGE OF THAT PERSON.** \_\_\_\_\_

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

**NAME OF SCHOOL CHILD ATTENDS?** \_\_\_\_\_

**RECREATIONAL ACTIVITIES?** \_\_\_\_\_

**DOES YOUR CHILD PRACTICE ANY DIET RESTRICTIONS?** \_\_\_\_\_  
(CIRCLE ALL THAT APPLY)

**LOW SUGAR  
LOW SODIUM  
LOW FAT  
LOW CARB**

**CARDIAC DIET  
NEUTROPENIC DIET  
VEGETARIAN  
DIABETIC DIET**

**WEIGHT LOSS DIET  
KETOGENIC  
GLUTEN FREE  
DAIRY RESTRICTED**

**DO YOU CURRENTLY HAVE PETS IN YOUR HOME?** \_\_\_\_\_  
(CIRCLE ALL THAT APPLY)

**DOGS  
CATS  
BIRDS**

**FISH  
RODENTS  
TURTLES**

**PIGS  
FOWL  
HORSES**

**RABBITS  
FARM ANIMALS  
REPTILES**

**HAS YOUR CHILD EVERY BEEN A VICTIM OF PHYSICAL ABUSE RESULTING IN INJURIES?**

\_\_\_\_\_

**HAS CHILD EVER HAD A MOTOR VEHICLE ACCIDENT RESULTING IN INJURIES?**

\_\_\_\_\_

**HAS YOUR CHILD HAD ANY OTHER TYPE OF ACCIDENT OR INJURY THAT WE SHOULD BE AWARE OF?** \_\_\_\_\_

**ARE THERE ANY UNUSUAL STRESS OR SAFETY ISSUES WE SHOULD BE AWARE OF?**

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

**FAMILY HISTORY / ILLNESSES**

**PLEASE LIST ANY MAJOR MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY. BE SURE TO INDICATE YOUR RELATIONSHIP TO THAT PERSON.**

CONDITION	√	RELATIVE
ASTHMA		
ARTHRITIS		
CANCER		
CEREBRAL PALSY		
DEMENTIA/ALZHEIMER'S		
DIABETES		
EPILEPSY/SEIZURES		
HEADACHES/MIGRAINES		
HEART ATTACK/DISEASE		
HIGH BLOOD PRESSURE		
MENTAL ILLNESS		
MENTAL RETARDATION		
MUSCLE DISEASE		
SICKLE CELL DISEASE		
STROKE		
THYROID DISEASE		

**IMMEDIATE FAMILY**

RELATIVE	AGE	HEALTH ISSUES	LIVING	CAUSE OF DEATH
FATHER/OCCUPATION				
MOTHER/OCCUPATION				
SIBLINGS				

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_

## **REVIEW OF SYSTEMS**

**PLEASE CIRCLE ANY CHANGES IN CONDITION OR SYMPTOMS YOUR CHILD IS CURRENTLY EXPERIENCING.**

**GENERAL:**

**ENERGY LEVEL, ACTIVITY, APPETITE, CHILLS, FATIGUE, FEVER, LETHARGY, TIRES EASILY, WEIGHT GAIN/LOSS.**

**EYES:**

**DROOPING EYELIDS, DRYNESS, GLAUCOMA, PAIN, IRRITATION/SCRATCHING SENSATIONS, VISION CORRECTIONS (GLASSES/CONTACTS) DIFFICULTY WITH VISION (BLURRED/DOUBLE) LAZY EYE**

**EARS/NOSE/MOUTH/THROAT:**

**DIFFICULTY UNDERSTANDING SPEECH, DECREASE IN HEARING, SENSITIVITY TO LOUD NOISES, RECENT INFECTIONS, PAIN IN EARS, VERTIGO/DIZZINESS, NOSE BLEEDS, FREQUENT COLDS, HAY FEVER, SNORING, SORES IN THE MOUTH, ABNORMAL DISCOLORATION OR TEETH, VOICE HOARSENESS, DROOLING**

**RESPIRATORY:**

**ASTHMA, BRONCHITIS, COUTH, PNEUMONIA, RECENT RESPIRATORY INFECTION**

**CARDIAC:**

**CHEST DISCOMFORT, HEART MURMURS, HIGH BLOOD PRESSURE, PALPITATIONS**

**GASTROINTESTINAL:**

**ABDOMINAL PAIN, CONSTIPATION, DIARRHEA, FOOD INTOLERANCE, NAUSEA, VOMITING, PAIN OR DIFFICULTY SWALLOWING**

**GENITOURINARY:**

**CHANGES IN URINE: VOLUME, COLOR, ODOR, INCONTINENCE, FREQUENCY, RECENT INFECTIONS**

**NEUROLOGICAL:**

**PROBLEMS WALKING, LOSS OF BALANCE, BLACKOUTS, BURNING SENSATIONS, CHANGES IN CONCENTRATION, CONFUSION/DISORIENTATION, CONVULSIONS, LACK OF COORDINATION, EXCESSIVE DROWSINESS, EPISODES OF DIZZINESS, FAINTING, HEADACHES, LIGHTHEADEDNESS, LOSS OF CONSCIOUSNESS, MEMORY LOSS, NUMBNESS, PARALYSIS, SEIZURES, SPEECH DIFFICULTIES, STARING SPELLS, TINGLING SENSATIONS, TREMORS, COMPLAINTS OF WEAKNESS**

**PSYCHIATRIC:**

**PERSONALITY CHANGES, COMPULSIVE BEHAVIOR, DEPRESSION, FEELS FUSSY, IRRITABLE, HOSTILE, NERVOUS, RESTLESS, MOOD SWINGS, SLEEP DISTURBANCES, UNUSUAL BEHAVIOR**

**ENDOCRINE:**

**CHANGES IN HAIR, LOSS OF HAIR, EXCESSIVE HUNGER/THIRST, EXCESSIVE URINATION, INCREASE/CHANGE IN BODY ODOR, INTOLERANCE TO HEAD/COLD**

**HEMATOLOGIC/LYMPHATIC:**

**ANEMIA, EASY BLEEDING, BRUISES, EASILY, SWOLLEN LYMPH NODES.**

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PHYSICIAN SIGNATURE**

**Physician Comments:**

**PHYSICIAN COMMENTS:**

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