

# Palm Beach Neurosurgery, LLC

Specializing in Surgical Diseases of the Brain, Spine and Nerves

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**Steven A. Dutcher, DO,**  
PhD, FAANS, FACOS  
Diplomate, American Board of  
Neurological Surgery  
Diplomate, American Board of  
Osteopathic Surgery

**Ramin Abdolvahabi, MD,**  
PhD, FAANS  
Diplomate, American Board of  
Neurological Surgery

**John D. Cantando, DO**  
Diplomate, American Board of  
Osteopathic Surgery

**Brett A. Schlifka, DO,**  
FACOS  
Diplomate, American Board of  
Osteopathic Surgery

Jessa Carter, PA-C  
Micah Kramer, PA-C  
Christine Sprenger, PA-C  
Ilana Sprague, PA-C  
Christina Esplen, PA-C  
Natalie Dargan, PA-C

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

Dear: \_\_\_\_\_

Your appointment is on: \_\_\_\_\_ at: \_\_\_\_\_,  
with

Dr. \_\_\_\_\_

in our \_\_\_\_\_ location.

You **MUST** have the following with you **upon arrival** or you will not be seen.

It is your responsibility to arrive with these items.

\*\* A referral is needed if your insurance is an HMO.

**DO NOT** depend upon your doctor to fax it. If a referral is not provided at the time of your visit, **you will not be seen.**

\*\* You **MUST** arrive with your MRI, XRAY, or CT scan pictures in hand, either on a film or disc. You will not be seen without pictures. No exception.

-Please understand the pictures are **NOT** sent to us, only the report is.

\*\*Please complete this packet at home & bring it with you to your appointment.

Thank You.

Directions to the office enclosed.

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Tel. 561-433-4444    3319 State Road 7    1880 N. Congress Ave.    601 University Blvd.    Fax. 561-433-8877  
                                 Suite #313                                   Suite #301                                   Suite #203  
Wellington, FL 33449    Boynton Beach, FL 33426    Jupiter, FL 33458

www.pbneurosurgery.com

**Palm Beach Neurosurgery, LLC**  
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**Steven A. Dutcher, DO, PhD, FAANS, FACOS**  
Diplomate, American Board  
of Neurological Surgery

**Ronel Bolink, ARNP-C**

**Deborah Diaz, PA-C**

**Ramin M. Abdolvahabi, MD, PhD, FAANS**  
Diplomate, American Board  
of Neurological Surgery

**Jessa Carter, PA-C**

**Micah Kramer, PA-C**

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

DATE:

I, \_\_\_\_\_ DOB: \_\_\_\_\_ GIVE PERMISSION TO

RELEASE MY MEDICAL RECORDS TO:

PALM BEACH NEUROSURGERY, LLC

3319 STATE ROAD 7

SUITE 313

WELLINGTON, FL. 33449

PHONE: 561-433-4444

FAX: 561-433-8877

FOR THE PURPOSE OF CONTINUED MEDICAL CARE.

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Tel. 561-433-4444

3319 State Road 7

Suite #313

Wellington, FL 33449

601 University Blvd.

Suite #203

Jupiter, FL 33458

Fax. 561-433-8877

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**PATIENT REGISTRATION & INFORMATION**  
**PLEASE PRINT**

Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Gender: \_\_\_\_\_ Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: Hispanic/Non-Hispanic/Other

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work # \_\_\_\_\_

\*Please choose one - Do you live in FL.  Full time or  Seasonal

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

Emergency Contact -Name, Relation & Phone #:

Primary Dr.: \_\_\_\_\_ Phone #: \_\_\_\_\_  
First Last

Referring Dr.: \_\_\_\_\_ Phone #: \_\_\_\_\_  
First Last

Is this visit due to an Auto Accident? \_\_\_\_\_ Work Injury? \_\_\_\_\_ Slip or fall? \_\_\_\_\_

Second Opinion? \_\_\_\_\_ Do you have a Legal Case Pending? \_\_\_\_\_ Due to? \_\_\_\_\_

\_\_\_\_\_  
Patient (or Responsible Party) Signature Date

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Tel. 561-433-4444 3319 State Road 7 1880 N. Congress Ave. 601 University Blvd. Fax. 561-433-8877  
Suite #313 Suite #301 Jupiter, FL 33458 Suite #203  
Wellington, FL 33449 Boynton Bch, FL 33426

# Palm Beach Neurosurgery, LLC

*Specializing in Surgical Diseases of the Brain, Spine and Nerves*

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

Dear Patient,

As part of our Electronic Medical Record (EMR) system you will be receiving an email from Palm Beach Neurosurgery, this is not SPAM. Using the link sent to you, you will create a username login and password. Using a secure server you will be able to view your demographic information on file as well as your allergies, medications, problems/diagnosis, family history, and vital signs recorded during your appointments. **There will be no communication to or from the office through this system.** If you have any questions please do not hesitate to contact our office at 561-433-4444.

EMAIL- PLEASE PRINT: \_\_\_\_\_

Thank You for Your Cooperation.

Ramin Abdolvahabi, MD, PhD, FAANS

Steven Dutcher, DO, PhD, FACOS, FAANS

John Cantando, DO

Brett A. Schlifka, DO, FACOS

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Tel. 561-433-4444 8877	3319 State Road 7 Suite #313 Wellington, FL 33449	1880 N. Congress Ave. Suite #301 Boynton Bch, FL 33426	601 University Blvd. Jupiter, FL 33458	Fax. 561-433- Suite #203
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## **PATIENT RESPONSIBILITIES:**

Please read the following carefully as they are your responsibilities.

- \*\* To inform office of any changes in insurance coverage.
- \*\* To inform office of any changes to address, phone number, or doctor's.
- \*\* To inform office if your visit is due to an accident related injury.
- \*\* **If you have HMO insurance, IT IS YOUR RESPONSIBILITY to provide us with a current and appropriate referral from your Primary Care Physician at the time of your visit. \_\_\_\_\_ (initials)**
- \*\* If your insurance requires a referral and you are seen without a valid referral, you understand that you will be responsible for any costs incurred for the visit.
- \*\* **To pay any applicable co-pays or balances due on the day of your visit.**
- \*\* **To provide the Doctor with any diagnostic films or disks he requests:**  
Note: when you have a diagnostic test (such as MRI, X-RAY, CT SCAN) it is **YOUR RESPONSIBILITY** to bring your films or disks along with the reports to your next visit. **YOUR PICTURES ARE NOT DELIVERED TO US NO MATTER WHAT THEY TELL YOU!!!!**  
\_\_\_\_\_ (initials)
- \*\* I understand there is a \$ 25.00 fee for any and all forms (e.g. Disability Forms) that may need to be filled out by the Doctor/staff on my behalf.

I, the patient, have read and understand the above responsibilities:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **HEALTH INSURANCE INFORMATION:**

### **PRIMARY INSURANCE**

Name of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ Co-pay \$: \_\_\_\_\_

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### **SECONDARY INSURANCE**

Name of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ Co-pay \$: \_\_\_\_\_

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### **TERTIARY INSURANCE**

Name of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ Co-pay \$: \_\_\_\_\_

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I AGREE THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
Patient (or Responsible Party) Signature

\_\_\_\_\_  
Date

**\*\*IF INJURY RELATED PLEASE ALSO FILL OUT ACCIDENT FORM\*\***

**Palm Beach Neurosurgery, LLC**  
**Financial and Office Policies**

*Thank you for choosing Palm Beach Neurosurgery, LLC as your healthcare provider. We are committed to your successful treatment and optimal experience in our office. Please familiarize yourself with our policies and procedures to ensure the highest quality of care.*

**FINANCIAL POLICY**

**Insurance**

Please understand that your insurance policy is a contract between you and your insurance company. Please ensure that we have updated information about your insurance at all time. We bill your insurance as a courtesy to you when provided with current information and an assignment of benefits, but the patient will be responsible for verifying their coverage and participating facilities, obtaining authorizations/referrals and ultimately paying the bill if the insurance company denies payment for services provided.

If your insurance requires a co-pay, it must be paid the day of your appointment or the appointment will be rescheduled. If your deductible hasn't been met, you will be required to make a payment the day services are provided. If your insurance cannot verify your coverage or you do not have insurance, you will be expected to pay in full the day of the services.

**Patient Balances:** All balances after insurance has processed will be due in full within 30 days. Any patient that has been placed on collections must pay any prior balance owed to the practice and the collection agency fee and/or attorney fees before the practice can schedule any future appointments. Patients sent to collections might have their debt reported to credit score agencies. **If your account is turned over to our collection agency Collection Information Bureau, Inc, patient will be responsible to pay the collection fee which is 25% of total patient responsible balance.**

**Surgery Deposit:** Self pay patients who are scheduled for an elective surgery will be asked to make a deposit of 75% of balance with our office prior to scheduling procedure. This allows us to reserve the operating time. Payment arrangements must be discussed with the billing office prior to surgery. Payments are not to exceed 3 installments after deposit.

**HMO Plans:** If you are required to have a PCP, please obtain a referral to see our providers. You are responsible for getting proper co-pay information in advance of your appointment.

**PPO Plans:** If we are in your network, we have agreed to accept the discounted rate from your plan, however all co-insurance, co-payments and deductible are your responsibility.

**Medicare:** After your insurance or secondary insurance has cleared we will send you a statement for the co-payment you are responsible for. Having more than one insurer does not necessarily mean that your services are covered 100%. As a courtesy we will bill your secondary insurance carrier, if they do not pay after 60 days you will be responsible for balance.

**Out of network PPO plans:** We will bill your insurance carrier as a courtesy. In the event charges are applied to your responsibility by your insurance carrier, we will expect payment at the time of service.

**Payment Plans:** Patients who have financial hardship to fulfill their financial obligation and whose balance is over \$500.00, might be eligible for a payment plan. Payment plans will not exceed 3 payments.

## **OFFICE POLICIES**

**Returned Checks:** All returned checks are subject to a processing fee of \$25.00 per transaction. This fee along with the original amount of the check will be due within 10 business days of the official notification given from Palm Beach Neurosurgery. A returned check, against a closed account or an account with non-sufficient funds (NSF), is in violation of civil law and, in certain situations (checks written over \$100), criminal law.

**Patient Forms:** Disability paper work will be filled out as a courtesy for patients during the post op period and whose balance has been paid. We also provide this service for patients for a fee of \$30-50, depending on complexity, to the patient.

**Missed/Canceled Appointments:** A \$50.00 charge may apply to missed appointments and appointments cancelled without 24 hours of notice. Appointment reminders are done as a courtesy and do not constitute a timely phone call or failure to appear.

I read and understand all of the financial and office policies. I agree to comply with these policies:

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**Printed Name**

**Signature**

**Date**



**Patient Consent Form**  
**Please read and sign.**

I am voluntarily seeking health care and hereby consent to medical treatment, procedures, diagnostic imaging, laboratory tests, and other health care services. The attending physician is responsible for the patients care. I, the Patient/Patients legal representative, understand that I have the right to refuse specific treatments or procedures; however, by signing below, I agree in general, to permit diagnostic imaging, laboratory tests, routine medical and mental health treatment, emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physician assisting in the care of the patient. By signing this I verify that I am at least 18 years of age.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand the Palm Beach Neurosurgery, LLC may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Drs. Dutcher, Abdolvahabi, Cantando, and Schlifka will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practiced.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or it's intermediaries for my Medicare claims. I assign the benefits payable for services to Palm Beach Neurosurgery, LLC/ Drs. Dutcher, Abdolvahabi, Cantando, or Schlifka

To obtain a copy of the Palm Beach Neurosurgery, LLC Notice of Privacy Practices please visit our website @ <https://www.pbneurosurgery.com>. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Patient (or Responsible Party) Signature

\_\_\_\_\_  
Date

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Ilana Sprague, PA-C  
Christina Esplen, PA-C  
Natalie Dargan, PA-C

Auto/WC/Liability Intake

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

Phone: \_\_\_\_\_

Carrier Name: \_\_\_\_\_

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

Carrier Phone: \_\_\_\_\_

Claim #: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Adjuster Phone: \_\_\_\_\_

Attorney Name: \_\_\_\_\_

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

Attorney Phone: \_\_\_\_\_

I understand Palm Beach Neurosurgery does not accept  
outside letters of protection. \_\_\_\_\_ (Initial)

I understand that when my benefits become exhausted, I  
assume financial responsibility. \_\_\_\_\_ (Initial)

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Suite #313  
Wellington, FL 33449

601 University Blvd.  
Suite #203  
Jupiter, FL 33458

Fax. 561-433-8877

**PALM BEACH NEUROSURGERY, LLC**

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RE: \_\_\_\_\_  
PATIENT'S NAME  
SS# \_\_\_\_\_

**LETTER OF PROTECTION**

I, (PRINT NAME) \_\_\_\_\_ DO HEREBY AUTHORIZE and direct my attorney, \_\_\_\_\_ to pay Palm Beach Neurosurgery, LLC and or its assignees any such sums as may be due and owing for professional services rendered to me by reason of the accident dated \_\_\_\_\_ and to withhold such sums from any settlement, judgment or verdict which may be necessary to adequately protect Palm Beach Neurosurgery, LLC as a result of the injuries for which I have been treated or injuries in connection therewith. I FULLY UNDERSTAND that I am directly and fully responsible to Palm Beach Neurosurgery, LLC for all bills submitted by Palm Beach Neurosurgery, LLC for services rendered to me and that this agreement is made solely for Palm Beach Neurosurgery, LLC'S additional protection in consideration of awaiting payment. Furthermore, I HEREBY AGREE to otherwise consent to Palm Beach Neurosurgery and/or its assignee's entitlement to intervene in any such actions, suit of claim which may be filed by patient or his/her attorney for the injuries treated by Palm Beach Neurosurgery, LLC. In addition, patient hereby acknowledges that the covenants and agreements made herein supersede any health or managed care contracts between patient's health care provider and Palm Beach Neurosurgery, LLC by which patient may be a direct or third beneficiary. I further understand and agree that payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I FINALLY UNDERSTAND that such payment for medical services rendered is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees.

\_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above, including Palm Beach Neurosurgery's and/or its assignee's entitlement to intervene in any action, suit or claim, and furthermore agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Palm Beach Neurosurgery.

\_\_\_\_\_  
Attorney's Signature

\_\_\_\_\_  
Date

**\*\*ALTERATIONS TO THIS DOCUMENT WILL BE DEEMED AS NULL AND INVALID\*\***

**PHARMACY INFORMATION**

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

Date of Birth: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_

Pharmacy Address or Cross Streets: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list any Advanced Directives you have, (i.e. ok to give blood  
or Do not resuscitate) if none please put none:**

\_\_\_\_\_

\_\_\_\_\_

## Authorization for Release of Information

**Name of Patient** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Palm Beach Neurosurgery, LLC is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

<u>Entity to Receive Information</u> Check each person/entity that you Approve to receive information	<u>Description of Information to be released</u> Check each that can be given to person/entity
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of Labs/Imaging <input type="checkbox"/> Other:
<input type="checkbox"/> Spouse (Name & phone #)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:
<input type="checkbox"/> Parent (Name & phone #)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:
<input type="checkbox"/> Other (Name & #)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:

### Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.*

Date \_\_\_\_\_

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

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

Main Complaint for your visit today: \_\_\_\_\_

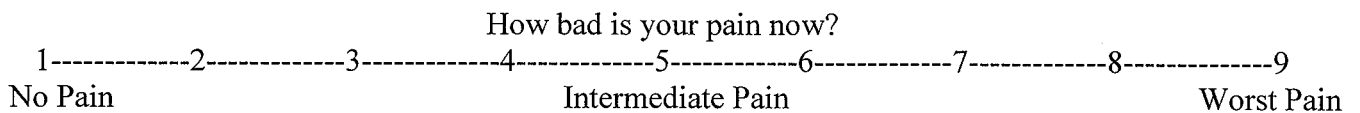
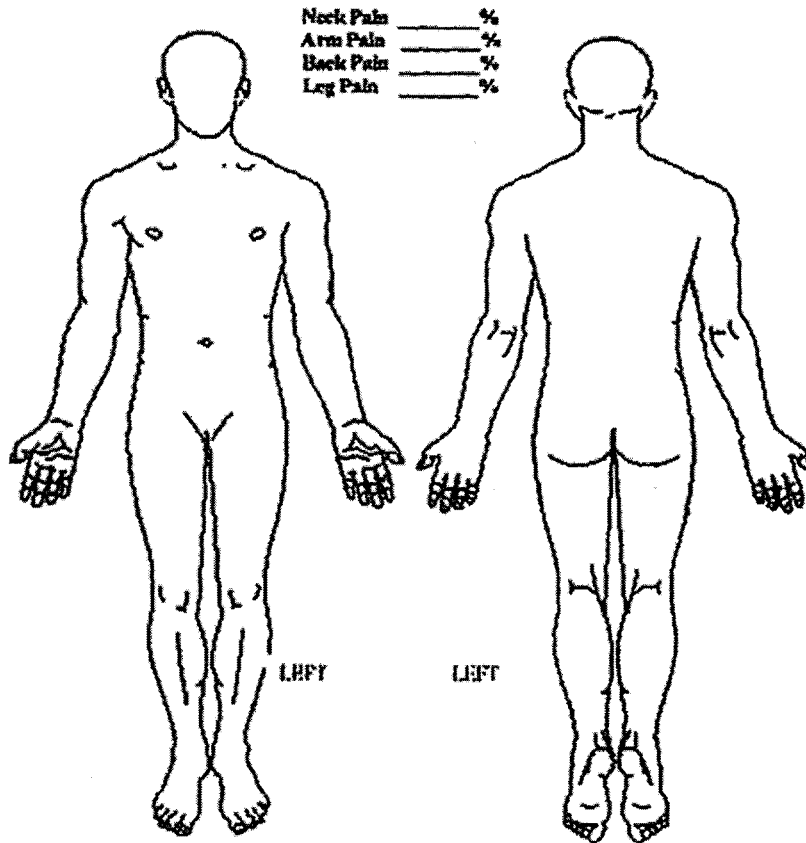
When did this pain/issue begin? : \_\_\_\_\_

### Where Is Your Pain?

Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol and mark the areas radiation also, include all affected areas.

Ache ^^^ ^^^ ^^^	Numbness OOO OOO OOO	Pins/Needles *** *** ***	Radiating Pain /// /// ///
------------------------	----------------------------	--------------------------------	----------------------------------

Please indicate the percentage (%) of pain that you have in the following areas, to be equal to 100%:



Patient Name: \_\_\_\_\_ Are you allergic to contrast dye? \_\_\_\_\_

Medication Allergies: \_\_\_\_\_ Food Allergies: \_\_\_\_\_

**ALL CURRENT MEDICATIONS & DOSAGE SPECIFICS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Are you on any blood thinners (medications)? \_\_\_\_\_

**MEDICAL HISTORY**

	Date Started				Date started		
AIDS	Yes	No	_____	Alcohol Depend.	Yes	No	_____
Alzheimer's	Yes	No	_____	Anemia	Yes	No	_____
Arrhythmias	Yes	No	_____	Asthma	Yes	No	_____
B Prost. Hyper.	Yes	No	_____	Bladder Infection	Yes	No	_____
Cancer Benign	Yes	No	_____	Cataracts	Yes	No	_____
Cancer Malig.	Yes	No	_____	Concussion	Yes	No	_____
Specify Type of cancer:	_____			Cirrhosis	Yes	No	_____
COPD	Yes	No	_____	Depression	Yes	No	_____
Diabetes	Yes	No	_____	Diverticulitis	Yes	No	_____
Drug Depend.	Yes	No	_____	Eye Problems	Yes	No	_____
Fibromyalgia	Yes	No	_____	Gall Stones	Yes	No	_____
GERD	Yes	No	_____	Glaucoma	Yes	No	_____
Gout	Yes	No	_____	Headache any	Yes	No	_____
Hearing impaired	Yes	No	_____	Heart disease	Yes	No	_____
Hemorrhoids	Yes	No	_____	Hepatitis- A, B, C	Yes	No	_____
High Cholesterol	Yes	No	_____	HIV	Yes	No	_____
Hydrocephalus	Yes	No	_____	Hypertension	Yes	No	_____
IBS	Yes	No	_____	Kidney Stones	Yes	No	_____
Meningitis	Yes	No	_____	Osteo. Arthritis	Yes	No	_____
Osteoporosis	Yes	No	_____	Paralysis	Yes	No	_____
Parkinson's	Yes	No	_____	Peptic Ulcer	Yes	No	_____
Pneumonia	Yes	No	_____	Psych Disorder	Yes	No	_____
Rheum. Arthritis	Yes	No	_____	Seizure Disorder	Yes	No	_____
Sleep apnea	Yes	No	_____	STD's	Yes	No	_____
Stroke	Yes	No	_____	Thyroid Disease	Yes	No	_____
Tuberculosis	Yes	No	_____	Urinary Infection	Yes	No	_____

**ARE YOU EXPERIENCING ANY OF THE FOLLOWING AT THIS TIME?**

Shortness of breath	yes	no	Chest pain	yes	no
Blood in stool	yes	no	Numbness	yes	no
Blood in urine	yes	no	Headaches	yes	no
Uncontrolled bladder	yes	no	Nausea	yes	no
Uncontrolled bowel	yes	no	Tingling	yes	no
Vomiting	yes	no	Ringling in ears	yes	no
Weakness	yes	no	Abnormal Vision	yes	no
Paralysis	yes	no	Abn. Weight Gain	yes	no
Hearing loss	yes	no	Abn. Weight Loss	yes	no

Any other symptoms related to your issue: \_\_\_\_\_

**Have you fallen in the past year?** Yes No **If yes, when and did it result in an injury? Please specify:**

\_\_\_\_\_

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

**LIST ALL SURGERIES. PLEASE BE SPECIFIC AS TO TYPE OF SURGERY & YEAR:**

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

Do you have any Metal or Implants in your body? \_\_\_\_\_  
 Previous treatment Brain or Spine and Dates: \_\_\_\_\_  
 Epidurals \_\_\_\_\_  
 Physical Therapy \_\_\_\_\_  
 MRI/CT SCAN/X-RAYS (location and date) \_\_\_\_\_

Family History

Members	Status	Year of Birth	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Other Please List
Father	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Mother	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Siblings	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Grandparents: Paternal: grandmother	Alive, Deceased, Unknown		Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	
grandfather	Deceased, Unknown		Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	
Maternal: grandmother	Alive, Deceased, Unknown		Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	
grandfather	Unknown Alive, Deceased, Unknown		Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	
Specify please								

How many -- Sisters \_\_\_\_\_ Brothers: \_\_\_\_\_ Daughters: \_\_\_\_\_ Sons: \_\_\_\_\_  
 Circle One -Alive/Deceased - Alive/Deceased - Alive/Deceased - Alive/Deceased

Any medical history \_\_\_\_\_  
 Do you smoke: yes no What, How much & how often: \_\_\_\_\_  
 Have you ever smoked: \_\_\_\_\_ If yes, when did you quit: \_\_\_\_\_  
 Do you drink: yes no What, How much & how often: \_\_\_\_\_  
 Do you use any recreational drugs: yes no Specify type: \_\_\_\_\_



