For internal use only

Test Date: ___/___/______

*Patient Name (*Please Print*): ______________________ Date: __________

***Please mark all that apply to the best of your ability and return upon completion.**
Do you have any of the following symptoms, conditions or illnesses?

CARDIOVASCULAR

High Blood Pressure ______
Heart Attack ______
Angina/Chest Pain ______
Heart Bypass Surgery ______
Pacemaker ______
Irregular Heartbeat ______
Atherosclerosis ______

RESPIRATORY

Asthma ______
Bronchitis ______
Emphysema ______
Recent Chest Infection ______
Shortness of Breath ______
Lung Disease ______
Lung Surgery ______

GASTROINTESTINAL

Jaundice ______
Gallstone ______
Liver Disease ______
Ulcers ______
Hiatal Hernia ______
Heartburn ______

SKIN

Pain in Arms (please circle one or both L | R) ______
Pain in Legs (please circle one or both L | R) ______
Pain/Tingling in Right Hand ______
Pain/Tingling in Left Hand ______
Pain/Tingling in Right Foot ______
Pain/Tingling in Left Foot ______

ENDOCRINE

Diabetes ______
Thyroid Disorder ______
High Cholesterol ______

PSYCHIATRIC

Depression ______
Psychiatric Care ______
Obsessive Compulsive Disorder ______

NEUROLOGICAL

Stroke ______
Seizures ______
Fainting ______
Dizziness or Lightheadedness ______
Headache or Migraines ______
Sleep Disorders ______
Sciatica ______
Fibromyalgia ______

HEMATOLOGIC /ONCOLOGIC

Bleeding Tendency ______
Easy Bruising ______
Anemia ______
Sickle Cell Disease ______
Blood Clots ______

EYES

Blurry Vision or Spots Before Eyes ______
Cataracts ______
Glaucoma ______

Other(s) (not listed above): ______________________

Dx (internal use only): ______________________

*Patient Signature ______________________ Date__________

Provider Signature ______________________ Date__________

I hereby authorize Autonomic Nervous System Testing on the above order(s).

Note: All testing should be considered medically necessary as defined by the OIG

Family Medical Home, PLLC
Jesus A. Rodriguez MD

Contraindications, Warnings, and Precautionary Notes

Contraindications describe a reason to withhold certain medical procedures. If *YES* is indicated to any of the conditions below, the ordering Physician will be notified to review the medical history prior to the assessment to ensure the safety and well-being of the patient. It is solely the discretion of the Physician if the screening will be performed if the answer is yes to any of the conditions below. Please inquire if a question or response is unknown, or further clarification is needed.

Please sign and date at the bottom. Thank You.

PLEASE CIRCLE YOUR SELECTION CHOICE

YES	NO	Are you fitted with a cardiac pacemaker?
YES	NO	Are you undergoing external defibrillation?
YES	NO	Do you have ANY implanted electronic devices (e.g. insulin pump)?
YES	NO	Are you fitted with metallic pins or prostheses (e.g. in your joints)?
YES	NO	Do you have an Intrauterine Device (IUD)?
YES	NO	Do you have a AV fistula or arterial catheter?
YES	NO	Are you missing one or more limbs?
YES	NO	Have you ever been diagnosed with a cardiac arrhythmia?
YES	NO	Have you had eye surgery in the last 30 days?
YES	NO	Have you ingested alcohol or stimulants (amphetamines) in last 12 hours?
YES	NO	Do you have excessive perspiration?

Patient
Signature : ______________________________ Date : ______________

Technician
Signature : ______________________________ Date : ______________