# Welcome to the Health Care Institute of North Florida!

Thank you for choosing our practice to provide your health care needs! We will sincerely do our best to make your visits as pleasant as possible, and will strive to provide you with the best medical care available.

This packet has been put together to give you some information regarding the physicians and providers in our office, and to present some guidelines about the services that we offer, and how they may better suit your needs.

Included in the packet is a brief history on each of our health care providers, and what services they are most suited to provide. A medical history form is also in the packet, and although we understand that it is somewhat lengthy, it is necessary to have this information to provide you with the best care possible.

Past medical history and hereditary information play a vital role in maintaining ongoing healthcare, and we encourage you to provide us with as much information as possible, and to ensure that this information is as accurate as possible. It will probably take some time to fill out this form, so **please make sure that you bring it with you to your appointment!** If you do not bring this form, you will have to fill out another one when you get here, and there is no way that we would be able to see you that day for your appointment.

Also enclosed are some guidelines regarding the policies and procedures for our office, and we would ask you to understand that we are regulated by many federal and state agencies including Medicare, OSHA, HIPAA, and the DEA. Some of our policies at first may seem a little excessive or unwarranted, but I would like to assure you that we are required to follow the standards set by these agencies, and are only doing what is necessary to provide each and every patient with the best care possible. Thank you for your understanding!

Once again, welcome to The Health Care Institute If you have any questions, please do not hesitate to call us at any time. We are ready to assist you in any way we can!

Sincerely,

*Blaton C. Wright*

Blaton C. Wright
Chief Executive Officer
The Health Care Institute

# The Health Care Institute of North Florida

We are pleased to introduce our health care providers!

**Richard L. Wright, Jr. MD, RPVI** is a Medical Doctor who attended under graduate school at the University of Florida and medical school at the University of Miami. He is Board Certified in Family Practice, and has been practicing in Lake City since 1977. He is also a Registered Physician in Vascular Interpretation. He is the Medical Director for the practice, and is considered one of the finest physicians in the state of Florida. He specializes in adult care, and treats many patients with multiple extreme and complex illnesses.

**Jeral Carr, PA-C** is a certified Physician Assistant who has been practicing in Lake City since 2003. He is retired from the US Navy, and has over 20 years experience as a Hospital Corpsman before attending PA school at Miami Dade College. He is qualified to see patients with all manner of illnesses, and also has an ever growing devotion of patients who will see no one but him.

**Kyle B. Wright, PA-C** is a certified Physician Assistant who graduated with a Master's of Physician Assistant Studies from the University of Florida in 2009. He has a growing devotion of patients and is qualified to manage patients with all manner of illnesses. He specializes in adult care, and treats many patients with multiple complex illnesses.

**Carol James, PA-C** is a certified Physician Assistant who graduated with a Master of Physician Assistant Studies from the University of Florida in 2012. She is qualified to see patients will all manner of illnesses, and has a growing devotion of female patients who prefer to see a woman for their yearly physicals.

**Carly Little, PA-C** is a certified Physician Assistant who graduated with a Master's of Physician Studies from Florida State University. She is an expert provider for many different illnesses, and she also manages our Allergy Treatment program.

We are extremely proud to have these excellent providers as part of our team! They are here to serve your needs, and we are confident that when it comes to healthcare, you could not be in better hands.

We would like to emphasize that the medical care for every single patient who is a part of this practice is overseen by a physician, and that they are receiving the best care possible!

# Notice of Privacy Practice

## Our Pledge to You

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain.

We are required by law to keep medical information about you private, to give you this notice of our legal duties & privacy practices with respect to medical information about you, and follow the terms of the Notice that are currently in effect.

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. If a change is made in policy, the Notice will be changed and posted in the lobby. You can receive a copy of the current Notice at any time. The effective date is listed just below the title.

## How we may use and disclose medical information about you.

We may use and disclose medical information about you for treatment, to obtain payment for treatment, and to support our health care operations. We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, coroner or medical examiner investigations, funeral arrangements and organ donation, workers' compensation purposes, product monitoring, repair and recall, lawsuits and disputes, to avert a serious threat to health or safety, national security intelligence activities, military command authorities, inmate information and emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

We may disclose medical information about you to a friend or family member who is involved in your medical care, or to disaster relief authorities so that your family can be notified of your location and condition.

The Health Care Institute will leave an appointment reminder on an answering machine if you are unable to answer your phone, and we will give you the date and time of the appointment made at that time.

## Other uses of medical information

In any situation not covered by this Notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us of your decision in writing.

# Your Rights

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us, or if it is determined that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6 year period and starting after April 14, 2003. You may receive the list in paper or in electronic form.

The first disclosure list request in a 12-month period is free; other requests will be charged for producing the list. We will inform you of the cost before you incur any costs.

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision of your request.

If you are concerned that your privacy right may have been violated, or you disagree with a decision we made about access to your records, you may contact Rayna Harris, our Privacy Officer.

All written requests or appeals should be submitted to our Privacy Officer,

**Rayna Harris**
**Health Care Institute**
**1289 SW State Rd 47**
**Lake City, FL 32024**

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Right. Our Privacy Officer will provide the address for you. Under NO circumstance will you be penalized for filing a complaint.

HCI VCI
HEALTH CARE INSTITUTE VEIN CARE INSTITUTE
OF NORTH FLORIDA

RICHARD L. WRIGHT, MD, RPVI
BOARD CERTIFIED FAMILY PRACTICE

ICAEL
Accredited Echocardiography Laboratory

Accredited Vascular Laboratory
Extracranial Cerebrovascular
Peripheral Arterial
Peripheral Venous

# FINANCIAL POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are insured by a plan we do business with but don't have an up-to-date insurance card on file in our office, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and deductible amount at each visit. **Please note that any balance that must be billed to the patient will incur a ten dollar ($10) service fee per statement. If the balance is due to an error on our part, there will be no service fee charged to you.**

3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers due to pre-existing, coordination of benefits, etc.. You have the right to refuse such treatment. If you continue with these services an ABN (advance beneficiary notice) must be signed and you must pay for these services in full at the time of service.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance coverage ends, and you have not secured a new policy at the time of your appointment, you will be placed into a self-pay status. This will require that you pay in full for your visit and any services done. If during any visit you are unable to pay your charges in full, this must be approved through our financial department.

7. **Nonpayment.** If your account is 60 days past due, you will receive a letter stating that you have ten (10) days to pay your account in full. Partial payments will not be accepted unless prior arrangements have been made through our financial services department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, credit reporting agency, or civil court and you **will be discharged from this practice**. If this is to occur, you will be notified by regular and certified mail that you have thirty (30) days to find alternative medical care. During that thirty (30) day period, our physician will only be able to treat you on an emergency basis.

8. **Missed Appointments**: Our policy is to charge for missed appointments not canceled within a twenty-four hour period. The charge for a missed appointment is $50.00. These charges will be your responsibility and billed directly to you. We understand that there are sometimes circumstances which are unavoidable. Please help us serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

**Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.**

# ADULT PERSONAL HISTORY FORM

If you intend to establish yourself as a patient in The Health Care Institute of North Florida, the following information will be essential in assisting your physician in discovering family tendencies towards certain diseases and silent illnesses of which you may be unaware. This information will also enable your physician to plan for your long term medical care and will provide necessary information should you become acutely ill and not be able to communicate your symptoms or past medical history.

NOTE: This History Form is a **CONFIDENTIAL** record and will not be released without your permission. PLEASE be as ACCURATE and THOROUGH as possible. We apologize for the length of the form but it is very important.

## ● IDENTIFYING DATA ●

Name _____ Age Today _____ Gender _____ Race _____

Marital Status (Circle one) Married Single Divorced Widow(er)

Present Employer _____ Occupation _____

Number of children _____ number of boys _____ number of girls _____ number living at home now ____

Date you last saw physician _____ Reason for that visit _____

## ● HISTORY OF PRESENT ILLNESS ●

List the single most important symptoms or reason for your visit today _____

_____

List all other symptoms or problems that you would like to have addressed: _____

_____

_____

## ● PRESENT MEDICATIONS ●

| | Name of Drug | Why Given? (What disease or medical problem) | How long taken? |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ |
| 8. | _____ | _____ | _____ |

**(Use additional space on last page of this form, if necessary; please list over-the-counter – non-prescription medicines also.)**

## ● CHILDHOOD ILLNESSES ●

(Birth to 17 years of age)

| | Yes | No |
|---|---|---|
| 1. Convulsions; fits, epilepsy | ☐ | ☐ |
| 2. Rheumatic fever | ☐ | ☐ |
| 3. Pneumonia | ☐ | ☐ |
| 4. Repeated ear infections | ☐ | ☐ |
| 5. Birth defects | ☐ | ☐ |
| What kind? Explain. _____ | | |
| _____ | | |
| 6. Meningitis | ☐ | ☐ |
| 7. Anemia | ☐ | ☐ |
| 8. Any other childhood illnesses? Explain. | ☐ | ☐ |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

## ● ADULT MEDICAL ILLNESSES ●

(17 years of age or older)

| Have you ever had: | Yes | No |
|---|---|---|
| 1. Hives | ☐ | ☐ |
| 2. Eczema | ☐ | ☐ |
| 3. Frequent skin infections | ☐ | ☐ |
| 4. Psoriasis | ☐ | ☐ |
| 5. Other skin diseases | ☐ | ☐ |
| Explain. _____ | | |
| 6. Glaucoma | | |
| 7. Cataracts | ☐ | ☐ |
| 8. Other eye diseases | | |
| Explain. _____ | | |
| 9. Pneumonia | ☐ | ☐ |
| 10. Tuberculosis or positive skin test | | |
| For TB (Tine, PPD) | ☐ | ☐ |
| 11. Emphysema | ☐ | ☐ |
| 12. Abnormal chest x-ray | ☐ | ☐ |
| Explain. _____ | | |
| 13. Asthma | ☐ | ☐ |
| 14. Other lung disease | ☐ | ☐ |
| 15. Rheumatic fever | ☐ | ☐ |
| 16. High blood pressure | ☐ | ☐ |
| 17. Heart attack | ☐ | ☐ |
| 18. Other heart disease | ☐ | ☐ |
| Explain. _____ | | |
| 19. Stomach ulcers | ☐ | ☐ |
| 20. Hiatal hernia | ☐ | ☐ |
| 21. Diverticulitis, diverticulosis | ☐ | ☐ |
| 22. Irritable bowel syndrome | ☐ | ☐ |
| 23. Gallstones | ☐ | ☐ |
| 24. Hepatitis | ☐ | ☐ |
| 25. Jaundice | ☐ | ☐ |
| 26. Other intestinal diseases | ☐ | ☐ |
| Explain. _____ | | |

| | Yes | No |
|---|---|---|
| 27. Frequent or recurrent urinary tract infections | ☐ | ☐ |
| 28. Prostatitis | ☐ | ☐ |
| 29. Enlarged prostate | ☐ | ☐ |
| 30. Syphilis | ☐ | ☐ |
| 31. Gonorrhea | ☐ | ☐ |
| 32. Other kidney or urinary tract diseases | ☐ | ☐ |
| Explain. _____ | | |
| 33. Arthritis | ☐ | ☐ |
| 34. Osteoporosis | ☐ | ☐ |
| 35. Scoliosis | ☐ | ☐ |
| 36. Other bone or joint diseases | ☐ | ☐ |
| 37. Meningitis | ☐ | ☐ |
| 38. Seizure, epilepsy (fits) | ☐ | ☐ |
| 39. Neuritis, neuralgia | ☐ | ☐ |
| 40. Stroke | ☐ | ☐ |
| 41. Anxiety, insomnia, nervousness | ☐ | ☐ |
| 42. Depression requiring medicine | ☐ | ☐ |
| 43. Other diseases of the nervous system | ☐ | ☐ |
| Explain. _____ | | |
| 44. Diabetes | ☐ | ☐ |
| 45. Cancer | ☐ | ☐ |
| 46. Goiter: Low or high thyroid condition | ☐ | ☐ |
| 47. Anemia | ☐ | ☐ |
| 48. Blood transfusions | ☐ | ☐ |
| When, why, how many units? _____ | | |
| 49. Breast disease | ☐ | ☐ |
| 50. Vaginal or uterine disease | ☐ | ☐ |
| 51. Any other female diseases | ☐ | ☐ |
| Explain. _____ | | |

## ● HOSPITALIZATIONS ●

(List all hospitalizations except for surgical admission. See Surgical history below for pure surgical admissions.)

| YEAR | DOCTOR | HOSPITAL, CITY | DIAGNOSIS (REASON FOR ADMISSION) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

(Use last page if necessary.)

## ● SURGICAL HISTORY ●

| YEAR | DOCTOR | HOSPITAL, CITY | TYPE OF SURGERY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

(Use last page if necessary.)

## ● ACCIDENTS OR SIGNIFICANT INJURIES ●

(Include workman's compensation injuries, athletic injuries and other significant injuries which led to medical treatment)

1. _____
2. _____
3. _____
4. _____

(Use last page if necessary.)

## ● IMMUNIZATIONS ●

| | (Age or date given) | | (Age or date given) |
|---|---|---|---|
| Tetanus shot | _____ | Last tuberculosis skin test | _____ |
| Measles shot | _____ | Last flu shot | _____ |
| Mumps shot | _____ | Pneumonia shot | _____ |
| Rubella shot | _____ | Hepatitis "B" shot | _____ |
| HIB (hemophilus influenza) | _____ | Other shots or immunization | _____ |

# ● FAMILY HISTORY ●

**INFORMATION:** This is a general list of the types of diseases that if a family member has may be medically important: Cancer of any type; diabetes (sugar); high blood pressure; insanity; suicide; alcohol or drug abuse; heart disease; heart attack, bypass surgery; kidney failure; congestive heart failure; seizure; leukemia; colon cancer; breast cancer; melanoma.

| RELATIVE | AGE NOW If ALIVE | LIST ALL SERIOUS MEDICAL PROBLEMS AND IF DEAD, CAUSE OF DEATH | APPROXIMATE AGE OF DEATH |
|---|---|---|---|
| FATHER | | | |
| MOTHER | | | |
| SISTER(S) | | | |
| | | | |
| | | | |
| BROTHER(S) | | | |
| | | | |
| | | | |

**Has any other relative living or dead had any of the diseases listed below?**
**Please enter relationship and any other information about the disease.**
**(Example: Maternal grandmother, breast cancer, age 34)**

1. Cancer _____
2. Diabetes _____
3. Heart disease (What kind?) _____
4. High blood pressure _____
5. Epilepsy _____
6. Insanity or other mental illnesses _____
7. Suicide _____
8. Alcoholism _____
9. Drug abuse _____
10. Other (describe) _____

# ● SOCIAL AND PERSONAL HISTORY; HABITS, ETC. ●

Have you ever lived in a foreign country? (List) _____

Have you traveled out of continental U.S. in last 2 years? (List places or countries) _____

How much caffeine do you drink? (tea, coffee, cokes, etc.) (cups or drinks per day) _____

Are you exposed to any toxic substances at home or work? (List) _____

Did you ever smoke? ____ Do you currently smoke? _____ (yes/no) age started _____; number packs per day _____

Did you ever drink alcohol? _____ Do you currently drink alcohol? _____ (yes/no) beer, wine, mixed drinks (circle)

Number of drinks per day average _____. Do you ever get drunk? _____ (yes/no); how often? _____

Have you ever used any street drugs such as marijuana, cocaine, etc.? (List) _____

# ● ALLERGIES ●

| NAME OF DRUG | TYPE OF ALLERGIC REACTION (Rash, breathing, nausea, abdominal pain, etc.) |
|---|---|
| | |
| | |
| | |
| | |
| | |

# ● REVIEW OF SYSTEMS ●

**SKIN●HAIR●NAILS** Yes No

1. Changes in size or color of skin lumps or growths you are concerned about ☐ ☐
2. Frequent or persistent infections of skin ☐ ☐
3. Unusual hair loss ☐ ☐
4. Recurrent rashes ☐ ☐
   Where? _____

**LYMPHATIC●HEMATOPOIETIC**

5. Blood transfusions ☐ ☐
   How many times? _____
6. Spontaneous bleeding ☐ ☐
7. Prolonged bleeding after a cut ☐ ☐
8. Any lymph nodes that did not go away ☐ ☐

**HEAD●EYES●EARS●NOSE●THROAT**

9. Frequent headaches ☐ ☐
10. Ringing in ears ☐ ☐
11. Hearing loss ☐ ☐
12. Do you wear glasses? ☐ ☐
    Date eyes last checked: _____
    By whom? _____
13. Nose bleeds ☐ ☐

**THORAX●BREAST●LUNGS**

14. Pain in breasts ☐ ☐
15. Lumps in breasts ☐ ☐
16. Pain in rib cage ☐ ☐
17. Persistent cough ☐ ☐
18. Do you cough up sputum every morning? ☐
    How much (teaspoon, tablespoon)? _____
19. Night sweats ☐ ☐
20. Date last chest x-ray _____

**CARDIOVASCULAR●VASCULAR**

21. Chest pain ☐ ☐
22. Shortness of breath ☐ ☐
    How many pillows do you sleep on? _____
23. Swelling of feet ☐ ☐
24. Fluttering of heart ☐ ☐
25. Leg cramps at night ☐ ☐
26. Leg cramps while walking ☐ ☐

Yes No

27. Fainting ☐ ☐
28. Told you had a heart murmur or hole in your heart ☐ ☐
29. Told you had blockage in neck blood vessels ☐ ☐

**GASTROINTESTINAL**

30. Recent increase or decrease in appetite ☐ ☐
31. Vomiting or nausea ☐ ☐
32. Belching, gas ☐ ☐
33. Heartburn ☐ ☐
34. Abdominal pain ☐ ☐
35. Diarrhea ☐ ☐
36. Constipation ☐ ☐
37. Frequent use of laxatives ☐ ☐
    What laxatives do you use? _____
38. Recent change in bowel habits ☐ ☐
    Describe. _____
39. Blood in stool or when you wipe from a bowel movement ☐ ☐
40. Hemorrhoids ☐ ☐
41. Hernia ☐ ☐

**MUSCULOSKELETAL**

42. Pain and swelling in joints ☐ ☐
    List the main joints involved _____
43. Other joint problems ☐ ☐
    List. _____
44. Burning on urination ☐ ☐
45. Difficulty in starting urinary stream ☐ ☐
46. Discharge (leaking) from penis ☐ ☐
47. Vaginal discharge ☐ ☐
48. Pain with intercourse (sex) ☐ ☐
49. Leaking of urine when coughing, sneezing or straining ☐ ☐
50. Any blood in urine ☐ ☐
51. Any bed wetting ☐ ☐
52. What do you use to prevent pregnancy? _____
53. How many times do you get up at night to urinate? _____

| **NERVOUS SYSTEM; PSYCHOLOGICAL** | Yes | No |
|---|---|---|
| 54. Convulsion, fits or seizures | ☐ | ☐ |
| 55. Fainting | ☐ | ☐ |
| 56. Paralysis | ☐ | ☐ |
| 57. Numbness | ☐ | ☐ |
| 58. Anxiety, depression | ☐ | ☐ |
| 59. Inability to sleep | ☐ | ☐ |
| **ENDOCRINE** | | |
| 60. Excessive sweating | ☐ | ☐ |
| 61. Inadequate erection | ☐ | ☐ |
| 62. Decreased sexual drive or loss of interest in sex | ☐ | ☐ |
| 63. Excessive thirst | ☐ | ☐ |
| 64. Unusual increase in appetite | ☐ | ☐ |
| 65. Weight loss | ☐ | ☐ |
| 66. Weight gain | ☐ | ☐ |

| **OBSTETRICAL, GYNECOLOGICAL** | Yes | No |
|---|---|---|
| 67. Age first menstrual period started _____ | | |
| 68. Are your periods regular (i.e., approximately 1 period each 24-35 days)? | ☐ | ☐ |
| 69. Any clots with periods | ☐ | ☐ |
| 70. Any pain with periods | ☐ | ☐ |
| 71. Describe flow: (heavy, light, moderate) _____ | | |
| 72. How many days do your periods last (average)? ___ | | |
| 73. Date of your last period. _____ | | |
| 74. Number of times pregnant including miscarriages __ | | |
| 75. Children living now _____ | | |
| 76. List any children that have died (age, cause) _____ _____ | | |
| 77. Number of C-sections _____ | | |
| 78. Number of premature births _____ | | |
| 79. What approximate age did your periods completely stop? _____ | | |
| 80. Do you have hot flashes? | ☐ | ☐ |
| 81. Any lumps in your breasts | ☐ | ☐ |
| 82. Discharge or leaking from your breasts | ☐ | ☐ |

Please list any comments about your general health or any specific problems that you would like to discuss in more detail or any continuation of partially answered questions earlier on this form.

_____

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