



Special Commission of Inquiry into the Ruby Princess

EXHIBIT 87

Case Summary: Paul Reid

INVOICE NO
BFC933E

RUBY PRINCESS MEDICAL CENTER

VISIT DATE
Mar 16, 2020

FOLIO	PATIENT NAME	CABIN	CRUISE NAME	TREATING PHYSICIAN
██████████	REID, PAUL (██████████)	██████████	R007	Dalvie, Zaeem MD

PATIENT ADDRESS

Australia

BILL PREPARER	CHARGE DATE	SETTLEMENT TYPE	POLICY NUMBER
Matthee, Johan Wilhelm RN	Mar 16, 2020 21:09 UTC+13:00	FOLIO	--

TOTAL PROFESSIONAL SERVICES	TOTAL MEDICATIONS	TOTAL SUPPLIES	TAX	TOTAL CHARGES
\$171.00	\$32.02	\$41.78	\$0.00	\$244.80

SKU	CPT	PROFESSIONAL SERVICE	PRICE	QTY	TOTAL
90711	--	Influenza A&B Test	\$42.00	1	\$42.00
91630	--	Doctor - Consultation, Office Hours - Level 1: Low to Moderate Complexity	\$129.00	1	\$129.00

SKU	MEDICATION	PRICE	QTY	TOTAL
MED150077	Loratadine Tablet 10mg	\$1.61	5	\$8.05
DEL0759	Dextromethorphan Hbr + Guaifenesin Syrup 20mg/200mg	\$23.97	1	\$23.97

SKU	SUPPLY	PRICE	QTY	TOTAL
54	Influenza A&B Testing Supplies	\$41.78	1	\$41.78

FINAL DIAGNOSIS

J06.9 - Acute upper respiratory infection, unspecified

ADDITIONAL DIAGNOSIS

R20.2 - Paraesthesia of skin

CASE SUMMARY

Ruby Princess - R007 (Mar 8, 2020 - May 1, 2020) - Mar 16, 2020 18:38 UTC+13:00

PATIENT ID	NAME	DATE OF BIRTH	GENDER	CABIN
██████████	REID, PAUL	██████████	M	██████████

Communicable Disease

DISEASE	SYMPTOMS STARTED	LAST SYMPTOMS	CABIN	NO. IN CABIN	REPORTED DATE
Acute Respiratory Disease	Mar 14, 2020 19:16 UTC+13:00	Mar 16, 2020 19:16 UTC+13:00	██████████	2	Mar 16, 2020 19:16 UTC+13:00

TEMPERATURE
37.1 C 98.8 F T

SYMPTOMS
Rhinorrhoea
Cough

OTHER SYMPTOMS
--

DETAILS

Received Current Seasonal Flu Vaccination: No
Close Contact of ARD Case: No
CXR: Not Done
Viral Culture: Not Done

Received Tamiflu: No
Pneumonia: No
Influenza Test: Flu A+B Negative
Legionella Urine Antigen: Not Done

SYSTEM DECISION

USER DECISION

ARI

ARI

MASTER LOG ADDITIONAL COMMENTS ⓘ

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REPORTABLE LOG COMMENTS ⓘ

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ISOLATION STARTED	ANTICIPATED ISOLATION RELEASE	RELEASED
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ADMIN
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Triage

DATE	PERFORMED BY	VISIT REASON
Mar 16, 2020 18:38 UTC+13:00	Bosman, Johanna Christina Maria RN	Illness

PRIORITY
NON-URGENT

CHIEF COMPLAINTS
Patient attends clinic for cough , runny nose , sweats and pins and needles in feet.

NOTES

Complaint: Dry cough, runny nose and sweats. Pins and needles in feet
Onset: 2 days ago
Medication taken: codral and aspirin

Vitals

DATE	PERFORMED BY
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Mar 16, 2020 18:40 UTC+13:00

BOSMAN, JOHANNA CHRISTINA MARIA RN

VITAL SIGNS

TEMPERATURE

37.1 C 98.8 F T

HEART RATE

72 bpm reg Radial

A.V.P.U

A

WEIGHT

108 kg Stated

COMMENTS

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BLOOD PRESSURE

143/95 LA sit

SPO2

95 SpO2 Finger Room air

PAIN SCORE

0

BODY MASS INDEX

36.2 BMI

MAP

111

RESPIRATORY RATE

15 breaths/min

HEIGHT

1.73 m

Allergy

No Known Allergies.

Medical History

DATE ONSET

--

DATE OF RESOLUTION

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DOCUMENTED BY

Bosman, Johanna Christina Maria RN

CONDITION

J45.9 - Asthma, unspecified

Chronic Illness

NOTES

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Surgical History

DATE

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LOCATION

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DOCUMENTED BY

Bosman, Johanna Christina Maria RN

SURGERY

Hernia Repair

NOTES

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Social History

FAMILY

Marital Status

Married

Education level

Some High School

Occupation	Bar Tender
Diet	Natural Foods Diet

SMOKING

Smoking History	No
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ALCOHOL

Alcohol History	No
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RECREATIONAL DRUGS

Recreational Drugs Use	No
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CAFFEINE

Caffeine Use	No
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EXERCISE

Exercise	Yes
Frequency	3 time(s) weekly
Type	Gym

HPI

DATE	PERFORMED BY
Mar 16, 2020 19:28 UTC+13:00	Dalvie, Zaeem MD

RHINORRHOEA AND COUGH

Guest reports a 2 day history of a dry cough, rhinorrhoea and a 'dry throat'.

He denies any pleuritic chest pain or dyspnoea.

No fever or myalgia reported.

He has been feeling lethargic.

He has been using 'Codral' - last dose taken this morning.

No influenza vaccine.

He has not traveled outside of Australia prior to the start of the cruise.

No contact with a suspected for confirmed case of COVID-19.

DATE	PERFORMED BY
Mar 16, 2020 19:28 UTC+13:00	Dalvie, Zaeem MD

PINS AND NEEDLES IN THE FEET

He also reports a 2 day history of paraesthesia to his feet bilaterally.

Symptoms are intermittent.

No weakness reported.

Review of Systems

DATE	PERFORMED BY
Mar 16, 2020 18:43 UTC+13:00	Bosman, Johanna Christina Maria RN

REVIEW OF SYSTEMS

Patient **states** Cough dry

Patient **denies** Change in appetite, Fever, Tiredness, Cough with sputum, Coughing up blood, Difficulty breathing, Wheeze/Asthma, Chest pain on breathing, Shortness of breath with exercise, Shortness of breath at night, Chest pain on exercise, Palpitations, Ankle swelling, Painful leg with exercise, Weight loss or gain, Abdominal pain, Indigestion, Heartburn, Painful or difficulty swallowing, Nausea, Vomiting, Diarrhea, Constipation, Rectal bleeding, Urination frequency, Nightly urination, Painful urination, Blood in urine, Poor stream, Urinary incontinence, Headaches, Dizziness, Tingling/Numbness, Weakness, Tremor, Fits/Seizures, Black-outs, Fecal incontinence, Visual disturbances, Heat or cold intolerance, Neck swelling, Menstrual disturbance, Erectile dysfunction, Increased thirst, Sweating, hot flashes, Muscle weakness, Joint aches, pains or stiffness, Joint swelling, Lumps/bumps, Ulcers, Rashes, Itchy skin, Changes to a mole, Bruising

Comments: runny nose

Sweating

Needles and pins in feet

Physical Examination

DATE	PERFORMED BY
Mar 16, 2020 19:28 UTC+13:00	Dalvie, Zaeem MD

MUSCULOSKELETAL

Ankles/Feet: Comments: Very subtle swelling to feet bilaterally.

No erythema noted.

Good DP pulses palpable bilaterally.

Normal sensation.

Normal power and ROM of ankles and toes..

DATE	PERFORMED BY
Mar 16, 2020 19:17 UTC+13:00	Dalvie, Zaeem MD

GENERAL

Well developed, well nourished, alert and cooperative, and appears to be in no acute distress. Mental status: Awake and Alert. Orientated. Cooperative. General: Pallor: Absent. Central Cyanosis: Absent.

EARS, NOSE, MOUTH AND THROAT

Throat: Posterior oropharynx: Posterior oropharynx has no erythema, exudate, lesions, or cobblestoning.

CARDIOVASCULAR

Auscultation: S1 and S2 normal, no murmur or gallop.

RESPIRATORY

Inspection: Respiratory rate and pattern: Normal. Stridor: None. Auscultation of the lungs: Clear to auscultation.

Physician Orders

STATUS	TASK	USER	DATE
Completed	INFLUENZA A&B TEST	Dalvie, Zaeem MD	Mar 16, 2020 19:17 UTC+13:00

LAB RESULTS

Influenza virus A Ag neg

Influenza virus B Ag neg

FINDINGS

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COMMENTS

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New Medications

DEXTROMETHORPHAN HBR + GUAIFENESIN SYRUP 20MG/200MG PO

10 Milliliter three times daily starting Mar 16, 2020 19:14 UTC+13:00 for 1 week(s)

LORATADINE TABLET 10MG PO

1 Tablet once daily starting Mar 16, 2020 19:14 UTC+13:00 for 5 day(s)

Diagnosis

DIAGNOSED DATE

Mar 16, 2020

PERFORMED BY

Dalvie, Zaeem MD

TYPE

Final

DIAGNOSIS

J06.9 - Acute upper respiratory infection, unspecified

NOTES

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DIAGNOSED DATE

Mar 16, 2020

PERFORMED BY

Dalvie, Zaeem MD

TYPE

Additional

DIAGNOSIS

R20.2 - Paraesthesia of skin

NOTES

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Note

DATE

Mar 16, 2020 19:29 UTC+13:00

PERFORMED BY

Dalvie, Zaeem MD

NOTES

He has been reassured about his feet symptoms.

Advised to follow up with his doctor at home if symptoms persist after the cruise.

DATE

Mar 16, 2020 19:16 UTC+13:00

PERFORMED BY

Dalvie, Zaeem MD

NOTES

He has his own supply of paracetamol and throat lozenges.

He has been advised to follow up if symptoms persist or worsen.

Disposition

MEDICAL DEPARTMENT DECIDED

TO

**Discharge from our care, follow
up if required**

PERFORMED BY

Dalvie, Zaeem MD

DATE

Mar 16, 2020 19:09 UTC+13:00

COMMENTS

Follow up if symptoms persist or worsen

DISCHARGE DOCUMENTS

Instructions

Prescriptions



24305 Town Center Drive
 Santa Clarita, California 91355
 Corporate: +1-661-753-0000
 Fax: +1-661-259-3108
 Internet: www.princess.com

MEDICAL RECORDS CONSENT AND EXPENSE PAYMENT AGREEMENT

PASSENGER/PATIENT ONBOARD OR SHORESIDE TREATMENT

Ruby Princess

Patient Family Name:	REID	Patient First name:	PAUL
Stateroom Number:	C621	Patient Date of Birth:	Apr 1, 1979
Email Address:		Cell Phone:*	
Mailing Address:			

*** If my cell phone is provided, I authorize Princess Cruise Lines, Ltd. ("Princess") to call me with any questions regarding any amounts owing under this Agreement.**

PAYMENT AND ASSIGNMENT

PAYMENT. I agree to pay any and all expenses incurred on my behalf or on behalf of the patient (regardless of whether the patient is my family member, traveling companion, or my minor child), which are related to the medical care received onboard and/or at a shoreside facility ("Medical Expenses"). Medical expenses include, but are not limited to, medical or dental services and fees, hospitalization costs, transportation costs, shoreside lodging, shoreside meals, medical evacuation, prescription medication and port agency assistance fees related to the medical care. I agree my obligation to pay for Medical Expenses (including the payment of shoreside service provider(s) directly, if required) is not voided if I or the patient (in the case where the patient is my family member, traveling companion, or my minor child) has medical insurance, supplemental health insurance, or Princess Vacation Protection (PVP) Cancellation and Passenger Protection Program travel protection, or independent travel insurance. I agree that Princess Cruise Lines, Ltd. ("Princess") is not obligated to advance any payment(s) to cover Medical Expenses and that if Princess does so, it is performed as a courtesy and I agree to reimburse Princess as described in this Agreement. In the event I am or the patient is (in the case where the patient is my family member, traveling companion, or my minor child) medically disembarked on an emergency basis and shipboard Medical Staff is unable to provide me with a copy of my shipboard medical bill prior to disembarkation, I authorize ship's Medical Staff to charge any onboard medical bill to my credit card on file and understand I will receive a copy of this medical bill from the shoreside Health Services Department. In the event I am or the patient is (in the case where the patient is my family member, traveling companion, or my minor child) medically disembarked on an emergency basis, I understand that neither myself nor the patient will be entitled to any cruise fare refund as a result of early disembarkation. This does not preclude myself and/or the patient (in the case where the patient is my family member, traveling companion, or my minor child) from filing any claims under any insurance policy that may have been purchased.

ASSIGNMENT OF INSURANCE BENEFITS. On behalf of myself or the patient (in the case where the patient is my family member, traveling companion, or my minor child), I assign all applicable medical insurance or travel protection ("Provider") benefits for Medical Expenses and agree to reimburse Princess for any non-covered Medical Expenses within (30) days of the date invoiced by Princess. I authorize any Provider to reimburse Princess directly for all monies advanced as payment for Medical Expenses incurred. I authorize Princess to submit any reimbursement claims directly to any Provider covering the Medical Expenses.

MEDICAL RECORDS CONSENT

CONSENT TO DISCLOSE HEALTH INFORMATION. I authorize Princess to contact any Medical Provider and to receive directly copies of any and all medical or other records related to Medical Services or billing provided to me or the patient (in the case where the patient is my family member, traveling companion, or my minor child). I also authorize Princess to release any information regarding Medical Care, which can include without limitation, medical history, symptoms, treatment, examination, results or diagnosis to any Medical Provider. I also hereby authorize Princess to provide any necessary information to my traveling companion(s) and/or next of kin of my condition, and agree that Princess will have no obligation to do so.

On behalf of myself or the patient (in the case where the patient is my family member, traveling companion, or my minor child), I hereby expressly consent to the disclosure of medical and other records described above to any or all of the following for the purposes specified:

- The Princess Health Services Department in the United States;
- Selected persons within the Princess Legal and Finance Departments who have need of these records for business or legal purposes related to my medical care;
- Any medical assistance company or medical provider for the purpose of assisting with or continuing medical care, should it be necessary for me or the patient (in the case where the patient is my family member, traveling companion, or my minor child) to be medically landed from the vessel;

- Any other medical professional that the Princess Health Services Department feels it appropriate to consult for the purpose of assisting in medical care;
- A third party contractor (including, without limitation, any legal or financial adviser and any debt collection service provider) for recovery of costs incurred by Princess in relation to the medical care; and
- Health care professionals to review the quality of care through the process of clinical audit.

I also authorize my travel insurance provider to provide any necessary information to Princess in relation to assisting me with care and repatriation if required.

It has been explained to me that if I do not consent to any of the above, I may refuse my consent by deleting the relevant section(s). However, I acknowledge that if I withhold my consent for the transfer of medical records to any of the above, this may prejudice my treatment or that of the patient (in the case where the patient is my family member, traveling companion, or my minor child) and any issues associated therewith.

LEGAL NOTICES

COLLECTION EXPENSES. I agree to pay on demand all the losses, costs, and expenses (including, without limitation, attorneys' fees and disbursements) which incur in connection with enforcement or attempted enforcement of this Agreement, or the protection or preservation of your rights under this Agreement, whether by judicial proceedings or otherwise. Such costs and expenses include, without limitation, those incurred in connection with any workout or refinancing, or any bankruptcy, insolvency, liquidation or similar proceedings.

WAIVER OF DEFENSES. I hereby waive any rights I may otherwise have under the legal defenses of diligence, demand, presentment, protest or further notice of any kind. Time is of the essence for the performance of each and every obligation under this Agreement.

LEGAL RESPONSIBILITY AND LIABILITY. All health and medical services onboard are provided solely for the convenience and benefit of patients who may be charged for such services. You accept and use medicines and medical services at your sole risk and expense without liability or responsibility of Princess whatsoever, and agree to indemnify Princess for all medical or evacuation costs or expenses incurred on your behalf. Doctors, nurses, and other medical staff members work directly for you as their patient. Therefore the course of medical treatment will be determined exclusively by the shipboard medical staff and you.

REJOINING VESSEL FOLLOWING SHORESIDE TREATMENT OR MEDICAL DISEMBARKATION. Medical clearance from a shoreside provider for a patient to resume a cruise, is not a guarantee that the patient will be allowed to do so. The shipboard doctor will make the final determination, based not only on diagnostic results and/or response to treatment but also on factors including but not limited to the likelihood of recurrence or worsening of your condition, length of cruise, ship's itinerary, and available clinical resources onboard. Princess will always take a conservative approach when it comes to the health and safety of our guests.

GOVERNING LAW. THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH MARITIME LAW AS APPLIED IN CALIFORNIA AND CALIFORNIA LAW TO THE EXTENT IT DOES NOT CONFLICT WITH MARITIME LAW, WITHOUT GIVING EFFECT TO ITS CONFLICTS OF LAW PRINCIPLES.

NOTICE: ANY HOLDER OF THIS CONSUMER CREDIT CONTRACT IS SUBJECT TO ALL CLAIMS AND DEFENSES WHICH THE DEBTOR COULD ASSERT AGAINST THE SELLER OF GOODS OR SERVICES OBTAINED PURSUANT HERETO OR WITH THE PROCEEDS HEREOF. RECOVERY HEREUNDER BY THE DEBTOR SHALL NOT EXCEED AMOUNTS PAID BY THE DEBTOR HEREUNDER.

BY SIGNING BELOW, I AGREE TO ALL THE TERMS AND CONDITIONS SET FORTH ABOVE

Patient's Signature

Paul Reid

Patient REID, PAUL
Mar 16, 2020 18:31 UTC+13:00

Guardian / Family Member / Traveling Signature

Mar 16, 2020 18:31 UTC+13:00



PRINCESS CRUISES

COMPLETE THE FOLLOWING SECTION FOR MEDICAL
CENTER ADMISSIONS.

SHORESIDE REFERRALS AND DISEMBARKATIONS
ONLY

24305 Town Center Drive
Santa Clarita, California 91355
Corporate: +1-661-753-0000
Fax: +1-661-259-3108
Internet: www.princess.com

THE FOLLOWING INFORMATION MUST BE PROVIDED FOR THE PATIENT

1. Is the patient covered by any other Group Medical Benefit Plan, Group Payment Plan, Medicare or Government Plan?

No ☐ Yes ☐

* If Yes, please provide the name of the Plan Sponsor, Policy Number and Claim Office Address of Primary Medical Carrier:

Name: _____ Policy No: _____ Address: _____

2. Does the patient have supplemental insurance, such as a Medicare supplement plan? No ☐ Yes ☐

*If Yes, please provide the name of Plan Sponsor, Policy Number and Claim Office Address of Supplemental Insurance Carrier:

Name: _____ Policy No: _____ Address: _____

3. Did the patient purchase Princess Vacation Protection (PVP) Cancellation and Passenger Protection Program or was it purchased on his/her behalf?

No ☐ Yes ☐

4. Is the patient insured through any other independent travel insurance plan? No ☐ Yes ☐

* If Yes, please provide the name of the Plan, Policy Number and Phone Number of Insurance Plan Carrier:

Name: _____ Policy No: _____ Address: _____

TRAVELING COMPANION

If I am signing as a Traveling Companion below, I agree that if I accompany the patient ashore, I will be responsible to pay for any and all personal costs resulting from this disembarkation at the time the costs are incurred. If Princess advances any of my expenses to accompany the patient, I will reimburse Princess for those advances and authorize Princess to charge my stateroom account and/or credit card for such advances.

Traveling Companion Signature

Mar 16, 2020 18:31 UTC+13:00

PATIENT REGISTRATION FORM

Please complete this form to assist the medical team provide you with better care.

Your personal health information will be protected in accordance with applicable privacy requirements.

Family Name:	Reid	Stateroom Number:	
First Name:	Paul	Date Of Birth: (e.g. 01-Sep-1964)	
Home City:	Sydney	Date:	16-3-20
Country of Residence:	Australia	Time:	6pm.

Past Medical History	Please check any previous health conditions, with the applicable dates.		
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Irregular Heart Rate	<input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Angina	<input checked="" type="checkbox"/> Asthma or COPD	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Mobility problems
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> Urinary infection
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Stomach Ulcer / Acid reflux	<input type="checkbox"/> Enlarged prostate
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer

Please list previous MEDICAL PROBLEMS with dates.	N/A
Please list previous SURGERIES with dates.	Hernia ops n 2 2018 2016
Please list all the MEDICATIONS you are taking and their dosages and frequency.	N/A
Please list any ALLERGIES to medications or other items.	N/A

Do you Smoke?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If yes, for how many years?	How many per day?
Do you drink Alcohol?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If yes, approximately how many units per week?	
Would you like a copy of your medical record for a nominal fee to assist with insurance claims?			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

PLEASE TURN OVER

What is your main complaint? When did it start?	Cough, runny nose, sweats, pins & needles in feet
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Do you have any of the following symptoms? Mark the corresponding box to indicate Yes or No:

General:	Yes	No	Ears, nose, eyes & throat:	Yes	No	Abdominal:	Yes	No
Change in appetite	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tiredness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Fever / chills	<input type="checkbox"/>	<input type="checkbox"/>	Ears blocked / hearing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Indigestion or heartburn	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Runny / blocked nose	slight	<input checked="" type="checkbox"/>	Nausea	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Respiratory & Cardio:	Yes	No	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (dry)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pain or swelling in face	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach/abdominal pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (with sputum)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Painful eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Abdominal swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (with blood)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Red eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pain/difficulty swallowing	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Wheezing	minor	<input type="checkbox"/>	Itchy or discharging eyes	1 eye	<input checked="" type="checkbox"/>	Eyes / skin yellow	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Change in voice	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Change in bowel habit	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Short of breath with activity or exercise	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Toothache, jaw pain or swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Loose bowel motions or diarrhea	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Short of breath at night	<input type="checkbox"/>	<input type="checkbox"/>	Visual changes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Constipation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Chest pain on breathing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neurological:	Yes	No	Fecal incontinence	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest pain with activity or exercise	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tingling or numbness	feet	<input checked="" type="checkbox"/>	Rectal bleeding, or blood in feces (black feces)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest pain at rest	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Headache	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Genital / Urinary:	Yes	No
Palpitations or abnormal heart beat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tremor or abnormal movements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Burning or pain with urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ankle or leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Urination frequency	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Musculoskeletal:	Yes	No	Fits / Seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Nightly urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Black-outs / fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Problems with balance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weakness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Poor stream	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Health:	Yes	No	Genital discharge or pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint or bone pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Disorientated / confused	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Menstrual / OBGYN issue	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Back or neck pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Anxious or distressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Skin:	Yes	No	Elevated mood (manic)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Endocrine:	Yes	No
Lumps or bumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Low mood or depressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heat or cold intolerance	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rashes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Abnormal behavior	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neck swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Itchy Skin	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Memory concerns	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sweating / hot flashes	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ulcers, abscess or sores	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Increased thirst	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Change in a pigmented lesion or moles	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Seeing, hearing or imagining things	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Breast mass, pain / discharge	<input type="checkbox"/>	<input checked="" type="checkbox"/>

By my signature below, I certify that the medical information provided is correct and acknowledge that I have read and understood all details stated in this form.

Patient First & Last Names:

Paul Reid

Date of Birth:
(e.g. 01-Sep-1964)

[Redacted]

Patient / Guardian Signature:

Paul Reid

Date: 16-3-20

Name of person completing form
(if not the patient):

Relationship to patient:

Signature:

Date: