NEW PATIENT INSTRUCTIONS – ALL NEW PATIENTS

If you are interested in making an appointment, please be sure you have reviewed all information on our website www.carolinacenter.com under "**NEW PATIENTS**", then "**HOW TO BECOME A PATIENT**" before completing these forms.

Please review "**Type of New Patients**" and then indicate which type office visit you prefer:

____ **Individual New Patient Visit - CANCER $1108**

____ **Individual New Patient Visit - $920 ($974 Wilmington New Patient)**

____ **Combined Individual New Patient Visit - $8 per person**

(Both individuals will need to complete separate Medical History forms and submit together)

____ **Expedited Colon Therapy - $282**

____ **Urgent Lyme-Tick Borne Illness - $475** ***(must be prescreened for this appointment type)***

- Please complete the **Medical History Form**.
- Complete and sign the **Patient Registration/Insurance Authorization Form**
- Provide us a **copy of your Insurance card, both front and back and a copy of your Driver's License** or other official identification which is required by the US Patriot Act. Failure to provide these documents will delay scheduling your appointment.
- Fill out the **Request for Medical Records** and give these to your primary care and/or specialty physicians to have them send us copies of any pertinent medical records and recent laboratory results. Do not have copies of x-rays sent as we only need the reports. Please make copies of any records you have and include in your materials prior to your initial office visit. Please be aware that any records provided will not be returned and we will not make copies of your records. Do not return this form to us.
- We require a **non-refundable $250 deposit** to process your initial paperwork. **The balance of $670 for the Individual Office Visit, $858 for Cancer Visit, $620 per person for Combined, $225 for Urgent Lyme, will be due at the time your initial office visit is scheduled.** This balance can be refunded up to 2 weeks prior to your actual office visit. **The $250 deposit is not refundable**. Send a check payable to: The Carolina Center or complete the following if you wish to make a credit / debit card payment.

____Visa ____MasterCard ____American Express ____Care Credit

Account #:_____Expiration: ____/____

Cardholder Name:_____

Cardholder Signature:_____

Please be aware of our **No Perfume-Scented Toiletries** policy and refrain from wearing any perfume or scented toiletries while at the clinic.

I have read all the information on the Carolina Center website under "New Patients" and "How to become a patient" and understand these procedures. I am requesting to become a patient of the Carolina Center and that it is highly recommended that I attend the "Introduction to the Carolina Center" Group Orientation. I understand that I will not be undergoing an evaluation at this Orientation. I understand that the **$250 deposit is nonrefundable** and I have reviewed the "**New Patient Cancellation Policy**".

_____ _____

Signature **Date**

Please check to be sure you have **ALL** the above items completed and return this form back to us.

Send all of this information to our office:

The Carolina Center for Integrative Medicine, P.A., New Patient Coordinator
4505 Fair Meadow Lane #111, Raleigh, NC 27607, Fax to: 919-571-8968 or E-mail: angel@carolinacenter.com

The Carolina Center for Integrative Medicine

New Patient Cancellation Policy

A non-refundable deposit of $250 is due upon receipt of the New Patient registration form and Medical History. The actual new patient appointment will then be scheduled following the initial "Orientation". At that time, the balance is due for payment for the initial office visit, Individual, Group or Expedited Colon Therapy.

This balance is fully refundable up to two weeks prior to the scheduled office visit. No refunds will be made if a cancellation request is received after this time period however patients will be allowed one opportunity to reschedule with a $150 cancellation fee. If this rescheduled appointment is then cancelled again or the patient is a no-show, the patient will not be allowed to reschedule any appointments and will forfeit all payments. Under these circumstances, the individual must reapply to be a new patient after a 3 month waiting period, submitting a new Patient Registration Form along with another $250 deposit. No credit will be given for any previous payments made. There will be no waivers of these fees for New Patients.

_____ _____

Signature Today's Date

New Patient Orientation – "Intro to The Carolina Center"

We greatly appreciate your interest in becoming a patient at the Carolina Center. In contrast with conventional medicine, integrative Medicine involves an entirely different way of thinking about health and the body; and the processes and procedures we follow are not always familiar to most people. We need to obtain a great deal of information from you in order to provide the best care, and just as importantly, there is much you will need to learn from us. While optional, it is strongly recommended that all incoming new patients attend one of our regularly scheduled **"Introduction to the Carolina Center"** Group Orientation during which time you will meet Dr. Pittman and learn the basics of a cellular-based integrative approach and as well as having your questions answered during the session. If you were unable to attend the New Patient Orientation prior to your initial office visit we encourage you to attend the next Orientation prior to your first follow-up office visit.

_____ ☐ ☐ _____

Signature I have I have not Today's Date

(Attended Orientation)

I am registered to attend Orientation on: _____

(Date of Orientation)

Date form filled out: _____

Patient Contact Sheet

Legal Name _____

What would you like us to call you? _____

Date of Birth: _____

Address/City/State/ZIP: _____

Insurance Carrier: _____

Policy Number: _____

Home Phone: _____ Work Phone: _____

Cell Number: _____ E-mail: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Fax Number _____

Best Phone Number to Reach You and/or Leave a Message concerning Appointments:

Best Phone Number to Reach You and/or Leave a Message concerning Prescriptions & other Medical Questions or Information at:

Emergency Contact: Name: _____ Phone Number: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

THE CAROLINA CENTER FOR INTEGRATIVE MEDICINE, P.A. - PATIENT REGISTRATION / INSURANCE FORM

Patient's Legal Name: (First, Middle Initial, Last):_____Social Security #: _____

Patient Address:_____County: _____

Home #:_____Cell #: _____

Sex M or F Birth date:_____Email address: _____

Marital Status: ____Single ____Married ____Divorced _____Widowed ____Domestic Partnership

Spouse's Name (if applicable):_____# of household members:_____Ethnicity: _____

Person responsible for payment: _____

Patient's Employer and Occupation: _____

Employer Address:_____Work #:_____Ext: _____

Primary Care Physician Name:_____Phone #: _____

DO YOU HAVE HEALTH INSURANCE? YES NO (Circle one) - If you answered YES, please provide a copy of your insurance card and complete the following:

Primary Insurance:_____Subscriber's Name: _____

Sex of Subscriber: M F Birth date of Subscriber:_____Social Security #: _____

Relationship to Patient:_____Policy #:_____Group #: _____

Secondary Insurance:_____Subscriber's Name: _____

Sex of Subscriber: M F Birth date of Subscriber:_____Social Security #: _____

Relationship to Patient:_____Policy #:_____Group #: _____

Emergency Contact: Name:_____Phone #:_____

Please tell us how you heard about our practice (circle one or more): Yellow Pages Newspaper Website Internet Family/Friend

Other: _____

Who can we thank for referring you to our practice? _____

Financial Obligation Statement

The services you are electing to receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of any and all charges incurred. As a courtesy, we will verify any insurance coverage and bill your insurance carrier on your behalf with the exception of Medicare, Medicaid, and Blue Cross Blue Shield; however, you are ultimately responsible for the payment of your bill. Payment for all office visits, procedures and other services is expected at the time the service is provided. Payment is also due immediately upon receipt of any bill presented to cover any deductible or coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim you will obligated for your account balance in full. I authorize my insurer to pay any benefits directly to Carolina Center for Integrative Medicine. I also agree to pay the Carolina Center the full and entire amount of all bills incurred by me within 30 days of treatment or upon receipt of any amount due after payment has been made by my insurance carrier. I understand that I will be assessed interest of 15% on any unpaid balance after 30 days and this interest will continue to accrue until payment is made in full. I have read the above policy regarding my financial responsibility to the Carolina Center for providing services to me. I certify that the information provided is, to the best of my knowledge, true and accurate.

Patient / Guardian Signature: _____ **Date:** _____

HIPPA Privacy Authorization Form

PATIENT NAME: _____

DOB: ___ /___ /____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

I, _____, hereby authorize Carolina Center for Integrative Medicine and/or any medical facility to release any and all medical information and test results that pertain to me, to the following person(s).

Name:_____ Phone #: (____)_____-_____ Relationship to pt. _____

Name:_____ Phone #: (____)_____-_____ Relationship to pt. _____

Name:_____ Phone #: (____)_____-_____ Relationship to pt. _____

I authorize Carolina Center for Integrative Medicine or the medical practice to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the practice.

I understand that I may revoke/cancel this authorization by notifying The Carolina Center in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian (if applicable) Date

_____ _____
Signature of Witness (Office Staff ONLY) Date

The Carolina Center for Integrative Medicine, P.A

John C. Pittman, M.D.
4505 Fair Meadow Lane, Suite 111
Raleigh, NC 27607
(919) 571-4391 Fax: (919) 571-8968

REQUEST FOR MEDICAL RECORDS

Authorization to Use/Release/Disclose Medical Information

Please give this form to your primary care doctor or any other physicians you have seen within the last several years so they are able to send copies of your medical records to us.

DO NOT RETURN THIS FORM TO THE CAROLINA CENTER

THIS IS FOR YOU TO TAKE TO YOUR REGULAR DOCTOR TO GET RECORDS SENT TO US

Patient Name (please print) _____

Date of Birth_____/_____/_____Social Security Number_____

Street Address_____

City_____State_____Zip_____

Home Telephone_____Work Telephone_____Ext._____

I request that copies of my complete medical records for the past six months along with any other pertinent labs or radiology reports related to my condition be sent to the Carolina Center for Integrative Medicine, P.A. at the above address

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

DO NOT RETURN THIS FORM TO THE CAROLINA CENTER – TAKE THIS TO YOUR REGULAR DOCTOR.

_____ _____

Signature of Patient or Guardian **Date**

NEW PATIENT HEALTH HISTORY

Our primary goal in your initial office visit is to review your health history since childhood, understanding the sequence of health care events of your life and how they may be linked leading us to your current state of health. It is enormously helpful for patients to provide this chronologic history for us in advance as this will expedite the visit, allow us to gain better information about the most important events in your life, and give more time to answer questions and discuss treatment considerations.

Please provide us the highlights of your health history being sure to incorporate the major topics noted below by either filling out this form or writing a narrative that allows you to expand on important issues. Please be concise, but elaborate on important details.

Major components of the health history:

- Chronologic history of health events and symptoms grouped by decades
- Details about major illnesses, hospitalizations, surgeries, trauma, pregnancies, symptoms, etc.
- Details about frequency of infections and use of antibiotics
- Any dental work other than routine cleanings, especially placement or removal of amalgam fillings
- Exposures to toxins, chemicals; history of work in potentially dangerous environments

Childhood:

Teens:

Twenties:

Thirties:

Forties:

Fifties:

Sixties:

Seventies and older:

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

Reason for your visit today _____

Recent and preventive medical care:

	Never	Mon/Yr	Results
Last physical examination:	[ ]	____/_____	
Last blood work/urinalysis:	[ ]	____/_____	
Last blood pressure check:	[ ]	____/_____	
Last EKG (electrocardiogram):	[ ]	____/_____	
Last chest x-ray:	[ ]	____/_____	
Other x-rays:	[ ]	____/_____	
Last vision check:	[ ]	____/_____	
Last hearing check:	[ ]	____/_____	
Last dental check/cleaning:	[ ]	____/_____	
Last stool test for bleeding:	[ ]	____/_____	
Last Sigmoidoscopic examination:	[ ]	____/_____	

Present Health Status:

Rate your present health status? [ ]Excellent [ ]Good [ ] Fair [ ] Poor

How much do you currently weigh?_____lbs How tall are you?_____ft_____in

How would you describe your body shape? [ ] Heavy [ ] Medium [ ] Small

Do you consider yourself: [ ] Lean [ ] Pudgy [ ] Obese [ ] Muscular [ ] Out-of-shape

Are you able to walk without assistance? [ ] Yes [ ] No
Without special agreement and arrangements, we are unable to accommodate patients who are not ambulatory due to the extra staff necessary for assistance. If you are in a wheelchair and wish to be a patient, you will need someone to come to all sessions with you as an assistant.

Have you ever had trouble getting IVs started in your arm? [ ] Yes [ ] No [ ] ???

What condition do you hope to improve here? _____

_____

Are you currently undergoing any treatment for this condition? [ ] Yes [ ] No

Brief history of this condition: _____

_____

_____

Please note any other major health or medical problems of which you are aware: _____

_____

Have you had any lab tests within last 6 months? [ ] No [ ] Yes - (Please include a copy with this form.)

MEDICAL HISTORY FORM

Patient Name_____ DOB_____ MR# _____

Present Medications:

Medication	Dosage	Frequency	Since
			___/___
			___/___
			___/___
			___/___
			___/___

Present Vitamins and Nutritional Supplements:

Name	Dosage	Frequency	Since
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___

Allergies/Adverse Reactions To: Side-effects:

Medications: _____ _____

_____ _____

_____ _____

Chemicals: _____ _____

_____ _____

Foods: _____ _____

_____ _____

_____ _____

Past Medical History:

Have you ever had (or do you now have) problems with:

VISION/EYES Glaucoma Near or far-sighted Need glasses Cataracts

Other:_____ Details: _____

HEARING/EARS Hearing loss Tinnitus (Ringing in ears) Frequent ear infections

Previous injury to the ears Recurrent Vertigo (Dizziness)

Other:_____ Details: _____

RESPIRATORY/ BREATHING Sinus infection Hay Fever Pneumonia Emphysema

Asthma Chronic Cough Tuberculosis Allergies

Other:_____ Details: _____

MEDICAL HISTORY FORM

Patient Name_____ DOB_____ MR# _____

HEART/ CIRCULATION
Rheumatic Fever, Rheumatic Heart Disease | High Blood Pressure
Other Heart Disease | Previous Heart Attack | Angina, Heart Pains
Heart Murmur | Stroke | Aneurysm | Abnormal EKG
Peripheral Vascular Disease (Poor Circulation) | High Cholesterol Level

DIGESTIVE SYSTEM
Gall bladder problems | Indigestion/Heartburn | Hemorrhoids | Pancreatitis
Colon polyps | Liver Disease | Abnormal Liver Function Tests
Ulcer - type:_____
Hernias - type: _____
Colitis - type: _____
Other:_____ Details: _____

KIDNEY/BLADDER
Kidney Stones | Glomerulonephritis | Urethritis
Frequent Bladder Infections | Kidney infection/pyelonephritis
Other:_____ Details: _____

ORTHOPÆDIC/BONES
Neck Pain or Surgery | Low Back Pain or Surgery | Loss of an Extremity
Arthritis | Other joint problem or surgery:_____
Other:_____ Details: _____

ENDOCRINE/GLANDS
Hypothyroid (Low thyroid) | Hyperthyroid (High thyroid) | Diabetes
Hypoglycemia (Low blood sugar)
Other:_____ Details: _____

BLOOD SYSTEM
Anemia | Bleeding disorder | Abnormal Hemoglobin
Other:_____ Details: _____

NEUROLOGICAL/ NERVES
Seizure disorder/Epilepsy | Recurrent Vertigo | Bell's Palsy
Neuritis/Inflammation of a Nerve | Pinched Nerve | Fainting or concussion
Other:_____ Details: _____

PSYCHOLOGICAL
Depression | Anxiety | Alcoholism | Substance Abuse
Other:_____ Details: _____

CANCER
If "yes", type of cancer:_____
Date discovered/diagnosed (mo/yr):_____/_____ Treatment:_____
_____

PREVIOUS SURGERY
Tonsillectomy | Appendectomy
Other: _____ Details: _____

OTHER HOSPITALIZATION OR SERIOUS ILLNESSES

Year/Reason:_____

Year/Reason:_____

Year/Reason:_____

What types of therapies have you previously used in the treatment of your condition? _____
_____
_____

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

Have you been to other health facilities or seen other practitioners for this problem? [ ] Yes [ ] No

If so, what did the treatment include? _____

_____

Was it effective? [ ] No [ ] Yes If "yes", what did the treatment accomplish? _____

_____

Major Family Illnesses: Has any relative had one or more of the following? (Please check all that apply.)
PGF: Paternal Grandfather * PGM: Paternal Grandmother * MGF: Maternal Grandfather * MGM: Maternal Grandmother

Disease	Relative
Cancer and type	PGF PGM_____ MGF_____ MGM _____ Father ____ Aunt Uncle Sister Brother Spouse _____ Mother_____ Children_____ Grandchildren _____ Other_____
Diabetes	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren Insulin Dependent? Yes If "yes", from what age?_____ No
Heart Disease	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren Age at onset: _____
High Blood Pressure	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren
Stroke	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren
High Cholesterol	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren
Bowel/Colon Disorders (Including polyps)	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren
Alcoholism	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren
Lung Disease	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren
Glaucoma	PGF PGM MGF MGM Father Mother Aunt Uncle Sister Brother Spouse Children Grandchildren

Family History

Relationship	Present age or age at death (indicate with a D)	State of Health	Major Illnesses (Cause of death if deceased)
Paternal Grandfather (PGF)	_____	Ex Good [ ] Fair [ ] Poor	_____
Paternal Grandmother (PGM)	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
Maternal Grandfather (MGF)	_____	Ex Good Fair Poor	_____
Maternal Grandmother (MGM)	_____	Ex Good Fair Poor	_____
Father	_____	Ex Good Fair Poor	_____
Mother	_____	Ex Good Fair Poor	_____
Brothers	_____	Ex Good Fair Poor	_____
	_____	Ex Good Fair Poor	_____
	_____	Ex Good Fair Poor	_____

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

Sisters	_____	Ex	Good	Fair	Poor	_____
	_____	Ex	Good	Fair	Poor	_____
	_____	Ex	Good	Fair	Poor	_____
Children	_____	Ex	Good	Fair	Poor	_____
	_____	Ex	Good	Fair	Poor	_____
	_____	Ex	Good	Fair	Poor	_____

Recent Symptoms:

Do you now have or have you had any of the following symptoms within the past 12 months:

VISION/EYES
- Blurred vision
- Double vision
- Eye infection
- Eye pain
- Change in vision
- Do you wear glasses?

HEARING/EARS
- Earaches
- Discharge from your ears
- Ringing or noise in your ears
- Hearing loss
- Family or friends noting that you have a hearing problem

RESPIRATORY/BREATHING
- Nose bleeds
- Head colds
- Sinus problems
- Hay fever
- Loss or change of smell or taste
- Hoarseness
- Sore throat
- Sores on your mouth or throat
- Chronic cough
- Coughing up blood
- Waking up at night short of breath

HEART & BLOOD VESSELS
- Chest pain
- Angina
- Pain radiating into your arms, neck, jaw, or shoulders
- Are you able to lie flat on your back in bed? _____
- High blood pressure
- Varicose veins
- Palpitations or heart fluttering
- Swelling of hands, feet, ankles _____
- Leg cramps while walking
- Leg cramps at night
- Shortness of breath after walking

DIGESTIVE SYSTEM
- Repeated stomach pain
- Heartburn
- Indigestion
- Gum problems
- Belching
- Change in appetite
- Nausea or vomiting
- Difficulty swallowing
- Vomiting up blood
- Constipation
- Black bowel movements
- Blood in stools
- Diarrhea (longer than 2-3 days)

ORTHOPÆDIC/BONES/JOINTS
- Recurrent back pain
- Joint aches
- Joint swelling
- Tingling or weakness
- Muscle spasms
- Numbness of hands or feet
- Trembling of hands or feet
- Recent fracture – Which bone? _____
- Problems walking or running
- Repeated injuries to the same area

KIDNEY/BLADDER
- Pain on urinating
- Difficulty starting urination
- Frequency or urgency of urination
- Blood in urine
- Incontinence (losing urine involuntarily)

SKIN
- Skin rash
- Easy bruising
- Moles that look unusual or changing
- Swollen glands or lymph nodes
- Chronic acne and eruptions

MEDICAL HISTORY FORM

Patient Name_____ DOB_____ MR# _____

ENDOCRINE/GLANDS
- Lump in throat
- Increased thirst
- Increased urination
- Unintentional weight gain
- Unintentional weight loss
- Excessive fatigue
- Discharge from nipples
- Decreased tolerance of heat
- Decreased tolerance of cold
- Change in texture of hair

NEUROLOGICAL/PSYCHOLOGICAL
- Frequent or severe headaches
- Fainting spells
- Dizziness
- Unconscious spells
- Numbness
  Where:_____
- Nervousness or depression
- Difficulty concentrating
- Insomnia, difficulty sleeping
- Nervous "tics"

FOR WOMEN ONLY

Yes	No	Change in vaginal discharge	Yes	No	Skipped or absent periods
Yes	No	Menstrual pain/dysmenorrhea	Yes	No	Pain or bleeding with intercourse
Yes	No	Increased menstrual bleeding	Yes	No	Is sex entirely satisfactory?
Yes	No	Breast lump or discharge	Yes	No	Pelvic Inflammatory Disease
Yes	No	Previous abnormal PAP smear	Yes	No	Venereal Disease

Results of last PAP smear:_____ Date: _/____/_____

Number of pregnancies:_____ Number of Live Births: _____

FOR MEN ONLY

Yes	No	Discharge from penis	Yes	No	Is sex entirely satisfactory?
Yes	No	Lump in testicles	Yes	No	Prostatitis
Yes	No	Enlarged Prostate	Yes	No	Impotence
Yes	No	Testicular tumor/problem	Yes	No	Venereal Disease

Lifestyle & Nutrition

Do you engage in any Cardiovascular or Aerobic exercise? Yes No

What type?_____ How often? _____

Do you engage in any Muscle Strength or Endurance exercise? Yes No

What type?_____ How often? _____

Do you engage in any Flexibility and Stretching exercise? Yes No

What type?_____ How often? _____

Diet: Do you have any special diet or food needs? Yes No

If "yes", please list considerations: _____

_____

Do you consume caffeinated beverages? Yes No How many do you consume per day? _____

Do you consume fish? Yes No How often?_____ Favorite type? _____

Do you consume dairy products? Yes No How often?_____ Favorite type? _____

Do you consume fried foods? Yes No How often?_____ Favorite type? _____

Describe the following typical meals:

Breakfast:_____

_____

Lunch:_____

_____

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

Dinner:_____

_____

What percentage of your diet is raw & uncooked? 0 - 25 | 25 - 50 50 - 75 75 - 100

Do you know the amount of fiber in your food daily? [Yes - Amount: _____ No

Have you changed your diet since the development of your condition? | Yes No

If "yes", how? _____

_____

Do you feel this change has improved your health? No Yes - _____

Drug and Alcohol Usage

Use of recreational drugs: Never 1 - 3 times per week 4 - 7 times per week > 7 times per week

How often do you drink beer?_____Wine?_____Hard Liquor?_____

Weight Control

Is weight control a problem for you? No Yes - Overweight | Underweight

Current height?_____Current weight:_____Ideal weight: _____

Weight 1 year ago:_____Highest previous weight:___

_____ Are you doing (have you done) anything to control your weight? [ ] No [ ] Yes - _____

Can you easily see the veins on your arms and legs? Yes No

Tobacco Usage

Do you currently use any form of tobacco? Yes No What type and how much do you use? _____

If you once used tobacco, what year did you quit? _____ What did you use? _____

Stress Management

Do you meditate? Yes No How often/for how long?_____

Do you practice other relaxation exercise? Yes | No How often? _____

Do you have any regular or leisure time activities? Yes No Type? _____

How many weeks of vacation do you take each year? _____

How stressful do you consider your life to be? High Moderate Slight Very Relaxed

Sleep Habits

Do you sleep well? Yes No How many hours of sleep do you actually get each night? _____

I certify that the above information is true and correct to the best of my knowledge. It is my responsibility to inform my physician if there are any changes in any of the information contained in this form.

_____ _____

Patient/Guarantor Signature Date