

## 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](http://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:

- Cancer New Patient Visit - \$1041**
- Standard New Patient Visit - \$969**
- Combined Family New Patient Visits - \$894 per person**  
(Both individuals will need to complete separate Medical History forms and submit together)
- Expedited New Patient Visit - \$757**
- Limited New Patient Visit - \$605** (must be prescreened for this appointment type)
- Expedited Colon Therapy - \$367**

- 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 \$791 for Cancer Visit, \$719 for the Standard Visit, \$644 per person for Combined, \$507 Expedited Visit, \$355 for Limited Visit and \$117 for Colon Therapy, will be due when your initial office visit is scheduled (not on the day of your appointment).** 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](mailto: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  
*(Attended Orientation)*

\_\_\_\_\_  
Today's Date

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 be 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:	<input type="checkbox"/>	____/____	_____
Last blood work/urinalysis:	<input type="checkbox"/>	____/____	_____
Last blood pressure check:	<input type="checkbox"/>	____/____	_____
Last EKG (electrocardiogram):	<input type="checkbox"/>	____/____	_____
Last chest x-ray:	<input type="checkbox"/>	____/____	_____
Other x-rays:	<input type="checkbox"/>	____/____	_____
Last vision check:	<input type="checkbox"/>	____/____	_____
Last hearing check:	<input type="checkbox"/>	____/____	_____
Last dental check/cleaning:	<input type="checkbox"/>	____/____	_____
Last stool test for bleeding:	<input type="checkbox"/>	____/____	_____
Last Sigmoidoscopic examination:	<input type="checkbox"/>	____/____	_____

## 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	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM _____	<input type="checkbox"/> MGF _____	<input type="checkbox"/> MGM _____	<input type="checkbox"/> Father _____	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Spouse _____
	<input type="checkbox"/> Mother _____	<input type="checkbox"/> Children _____	<input type="checkbox"/> Grandchildren _____	<input type="checkbox"/> Other _____				
Diabetes	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Grandchildren			
	Insulin Dependent? <input type="checkbox"/> Yes If "yes", from what age? _____							<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Grandchildren	Age at onset: _____		
High Blood Pressure	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Grandchildren			
Stroke	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Grandchildren			
High Cholesterol	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Grandchildren			
Bowel/Colon Disorders (Including polyps)	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
Alcoholism	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Grandchildren			
Lung Disease	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Grandchildren			
Glaucoma	<input type="checkbox"/> PGF	<input type="checkbox"/> PGM	<input type="checkbox"/> MGF	<input type="checkbox"/> MGM	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle
	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Grandchildren			

## Family History

Relationship	Present age <u>or</u> age at death (indicate with a D)	State of Health	Major Illnesses (Cause of death if deceased)
Paternal Grandfather (PGF)	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____
Paternal Grandmother (PGM)	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____
Maternal Grandfather (MGF)	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____
Maternal Grandmother (MGM)	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____
Father	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____
Mother	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____
Brothers	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____
	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____
	_____ <input type="checkbox"/> Ex <input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	_____

# MEDICAL HISTORY FORM

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ MR# \_\_\_\_\_

Sisters	_____	<input type="checkbox"/> Ex	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	_____
	_____	<input type="checkbox"/> Ex	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	_____
	_____	<input type="checkbox"/> Ex	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	_____
Children	_____	<input type="checkbox"/> Ex	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	_____
	_____	<input type="checkbox"/> Ex	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	_____
	_____	<input type="checkbox"/> Ex	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> 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

- |                              |                             |                              |                              |                             |                                   |
|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|-----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Change in vaginal discharge  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skipped or absent periods         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Menstrual pain/dysmenorrhea  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pain or bleeding with intercourse |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Increased menstrual bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is sex entirely satisfactory?     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breast lump or discharge     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pelvic Inflammatory Disease       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Previous abnormal PAP smear  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease                  |

Results of last PAP smear: \_\_\_\_\_ Date: / \_\_\_\_ / \_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of Live Births: \_\_\_\_\_

## FOR MEN ONLY

- |                              |                             |                          |                              |                             |                               |
|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|-------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Discharge from penis     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is sex entirely satisfactory? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lump in testicles        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostatitis                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Enlarged Prostate        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Impotence                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Testicular tumor/problem | <input type="checkbox"/> Yes | <input type="checkbox"/> 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