

**AMERICA'S CLINICS FOR PREVENTIVE MEDICINE**  
**WILLIAM E. RICHARDSON, M.D.**  
**950 Cobb Parkway, Suite 191**  
**Marietta, Georgia 30060**

**OUR FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information Form before seeing the Doctor.

- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, MONEY ORDER, AMERICAN EXPRESS, AND CARE CREDIT.
- WE DO NOT ACCEPT ANY INSURANCE PLANS, EXCEPT MEDICARE.

Adult Patients: Adult patients are responsible for full payment at the time of service.

Minor Patients: The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a Visa/MasterCard, or payment by cash or check at the time of service has been verified.

Missed Appointments: Unless canceled, at least 24-hours in advance, our policy is to charge a no-show fee. It is agreed and understood by patients that they will pay a fee of \$75.00 in the event that they do not notify this office 24-hours in advance of missing any scheduled appointment. I also understand that I will remit any no-show fee at the time of my next appointment. If not, my appointment privileges may be temporarily suspended. Legitimate emergencies will be waived, but proof of the emergency will be requested.

If you (the patient) miss office visits with Dr. Richardson or other prescribed appointments or therapy, this office is not liable for any adverse physical, mental or emotional complications resulting thereof.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

XX \_\_\_\_\_  
Signature of Patient or Responsible Party                      Date

XX \_\_\_\_\_  
Signature of Co-Responsible Party

Date

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## FINANCIAL POLICY

### "SUMMARIZED"

- **Full Payment Is Due at Time of Service**
- **No Post-dated Checks Accepted**
- **No Payment Plans Available**
- **Please Consult With Our Staff Before Your Appointment, If You Need to Discuss Finances**
- **Checks Written For Insufficient Funds, Will Require Cash or Money Order Immediately For Original Amount, Plus a \$50 Service Fee**
- **We Do Accept Cash, Local Checks, Visa/MC/American Express or Money Order**

I understand and agree to this Financial Policy

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date



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LIFESTYLE HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

NUTRITION REVIEW:

Are you a vegetarian? \_\_\_\_\_ Yes \_\_\_\_\_ No A raw/live food eater \_\_\_\_\_ Yes \_\_\_\_\_ No

Type of food you eat most often: \_\_\_\_\_ Fresh \_\_\_\_\_ Frozen \_\_\_\_\_ Canned \_\_\_\_\_ Boxed \_\_\_\_\_ Restaurant \_\_\_\_\_ Fast Food

How many times a day do you normally eat? \_\_\_\_\_

Write in typical examples of your dietary profile:

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you eat/drink the following?

Food/beverage	Preference	Number of times	
		Daily	or Weekly
_____ Milk _____ Goat _____ Human	_____ Low fat		
_____ Cow	_____ Whole		
_____ Rice _____ Soy	_____ 1%		
_____ Juice _____ Vegetable	_____ Fresh		
_____ Fruit	_____ Frozen		
	_____ Canned		
_____ Tea	_____ Regular		
	_____ Herbal		
What type of sweetener do you use on foods and in beverages?			
_____ Sugar	_____ Sweet 'n low _____ Sucanat		
_____ Honey	_____ Saccharin _____ Other _____		
_____ NutraSweet (aspartame)	_____ Stevia		

I consume caffeine in the amount of \_\_\_\_\_ cups, cans, bottles per day.

I consume \_\_\_\_\_ cups of water per day. Sources: \_\_\_\_\_ Tap \_\_\_\_\_ Bottles / spring \_\_\_\_\_ Distilled \_\_\_\_\_ Filtered \_\_\_\_\_ Well

Do you consume alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, the Amount is: Beers/wk \_\_\_\_\_ Wine/wk \_\_\_\_\_ Liquor/wk \_\_\_\_\_

**DAIRY:**

What Dairy Products (Other than Milk) Do You Use (Indicate Frequency):

- \_\_\_\_\_ Butter
- \_\_\_\_\_ Margarine; Type \_\_\_\_\_
- \_\_\_\_\_ Sour Cream
- \_\_\_\_\_ Cream (Whipped, Heavy, Light, Etc.)
- \_\_\_\_\_ Cottage Cheese
- \_\_\_\_\_ Cheese
- \_\_\_\_\_ Other (Please Specify): \_\_\_\_\_

What Type of Muffins, Cookies, Cereals, Breaks, Etc.:

- \_\_\_\_\_ White
- \_\_\_\_\_ Whole Wheat
- \_\_\_\_\_ Oat Bran
- \_\_\_\_\_ Rice Bran
- \_\_\_\_\_ Others (Specify) \_\_\_\_\_

Do you eat nuts and grains? \_\_\_\_\_ Yes \_\_\_\_\_ No

What nuts and grains do you eat most often?

Do you have vegetables daily? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 When you have them, are they \_\_\_\_\_ Fresh \_\_\_\_\_ Frozen  
 \_\_\_\_\_ Canned \_\_\_\_\_ Raw \_\_\_\_\_ Cooked \_\_\_\_\_ Other  
 \_\_\_\_\_ Combination

What vegetables do you eat most often?

Do you have fruit daily? \_\_\_\_\_  
 When you have fruit, is it usually: \_\_\_\_\_ Fresh \_\_\_\_\_ Frozen  
 \_\_\_\_\_ Canned \_\_\_\_\_ Raw \_\_\_\_\_ Cooked \_\_\_\_\_ Dried

What fruits do you eat most often?

MEAT: At least  
 What Meats Do You Consume? Daily / once a week.  
 Beef \_\_\_\_\_  
 Chicken \_\_\_\_\_  
 Pork \_\_\_\_\_  
 Veal \_\_\_\_\_  
 Turkey \_\_\_\_\_  
 Lamb \_\_\_\_\_

What type of Fish/Seafood Do You Eat?  
 \_\_\_\_\_ Freshwater \_\_\_\_\_ Fish \_\_\_\_\_ Saltwater \_\_\_\_\_ Shellfish  
 \_\_\_\_\_ Crab \_\_\_\_\_ Lobster \_\_\_\_\_ Mussels \_\_\_\_\_ Shrimp  
 How Often?  
 Do You Eat Canned Fish? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 What Type:  
 How Often?

What Type of Cookware Do You Use?

- \_\_\_\_\_ Glass \_\_\_\_\_ Aluminum \_\_\_\_\_ Cast Iron
- \_\_\_\_\_ Porcelain \_\_\_\_\_ Stainless Steel \_\_\_\_\_ Waterless
- \_\_\_\_\_ Other (Specify) \_\_\_\_\_

What Type of Dishes Do You Have/Use Most Often?

- \_\_\_\_\_ Glass \_\_\_\_\_ Plastic \_\_\_\_\_ Paper \_\_\_\_\_ Ceramic \_\_\_\_\_ China \_\_\_\_\_ Other (Specify) \_\_\_\_\_

What Processed Foods Are In Your Diet?

- \_\_\_\_\_ TV or Frozen Dinners \_\_\_\_\_ Lunch Meat
- \_\_\_\_\_ Hotdogs \_\_\_\_\_ Cheeses
- \_\_\_\_\_ Others: Please List \_\_\_\_\_

Do You Frequently Skip Meals? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, Which Meal Do You Most Often Skip? \_\_\_\_\_  
 Why? \_\_\_\_\_

Do You Feel Better After Eating or Worse? \_\_\_\_\_ Better \_\_\_\_\_ Worse

Do Certain Foods Irritate You In Some Way? \_\_\_\_\_ Yes \_\_\_\_\_ No Which Ones \_\_\_\_\_

Describe Symptoms For Foods That Irritate: \_\_\_\_\_

Do You Crave Certain Foods/Spices? \_\_\_\_\_ Yes \_\_\_\_\_ No Which Ones \_\_\_\_\_

What Foods Do You Especially Like/Dislike/Avoid?

- Like: \_\_\_\_\_
- Dislike: \_\_\_\_\_
- Avoid: \_\_\_\_\_

Do You Feel Your Diet Is Excessive/lacking/deficient in Some Respect?

Describe:

Do You Gain/Lose Weight Easily?      \_\_\_\_\_ Gain      \_\_\_\_\_ Lose

Have You Ever Smoked Cigarettes?      \_\_\_\_\_ Yes      \_\_\_\_\_ No

If Yes, How Many Packs Per Day? \_\_\_\_\_      How Many Years? \_\_\_\_\_

Do You Smoke Now?      Yes \_\_\_\_\_      No \_\_\_\_\_

If No, How Many Years Ago Did You Quit? \_\_\_\_\_

How Many Bowel Movements Do You Have Per Week? \_\_\_\_\_

Circle One:      Light                  Moderate                  or Heavy

How Many Times Do You Exercise Every Week?      Type of Exercise:

Aerobic      Yes \_\_\_\_\_      No \_\_\_\_\_

Stretching      Yes \_\_\_\_\_      No \_\_\_\_\_

Muscle Toning      Yes \_\_\_\_\_      No \_\_\_\_\_

List Activities You Do The Last Hour Prior to Bed: \_\_\_\_\_  
\_\_\_\_\_

What Time Do You Normally Go To Bed? \_\_\_\_\_ A.m. / P.m.

What Time Do You Normally Get To Sleep? \_\_\_\_\_ A.m. / P.m.

What Time Do You Normally Wake Up? \_\_\_\_\_ A.m. / P.m.

List Activities You Do the First Awake Hour: \_\_\_\_\_  
\_\_\_\_\_

What Time Do You Normally Have To Be At Work? \_\_\_\_\_ A.m. / P.m.

What Time Do You Get Home From Work? \_\_\_\_\_ A.m. / P.m.

Please List Any Nutritional Supplements, Vitamins That You Are Taking:

\_\_\_\_\_  
\_\_\_\_\_

## OTHER LIFESTYLE/NUTRITION/ENVIRONMENTAL QUESTIONS

1. How often do you meditate? \_\_\_\_\_ How long? \_\_\_\_\_  
Pray? \_\_\_\_\_ How long? \_\_\_\_\_
2. Which Religion/Spiritual Path (if any) do you profess to follow? \_\_\_\_\_  
How much do you read, study, follow, and practice your Religion/Spiritual Path? \_\_\_\_\_  
\_\_\_\_\_ a lot \_\_\_\_\_ frequently \_\_\_\_\_ sometimes \_\_\_\_\_ very little
3. List the Top 5 Books you have read on Health and Nutrition
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
4. List the Top 5 Inspirational/Motivational/Spiritual Books you have read on Healing, Unconditional Love, Forgiveness
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
5. What percentage of your diet is completely Live/Raw (uncooked and unprocessed)?  
\_\_\_0% \_\_\_10% \_\_\_20% \_\_\_30% \_\_\_40% \_\_\_50% \_\_\_60% \_\_\_70% \_\_\_80% \_\_\_90% \_\_\_100%
6. Do you use commercial deodorant? \_\_\_\_\_ yes \_\_\_\_\_ no  
Soaps? \_\_\_\_\_ yes \_\_\_\_\_ no  
Cosmetics? \_\_\_\_\_ yes \_\_\_\_\_ no
7. Do you use fluoridated toothpaste? \_\_\_\_\_ yes \_\_\_\_\_ no
8. What 3 places do you shop for your Food and other Health Items? (Be specific):
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
9. Do you own a Juicer? \_\_\_\_\_ yes \_\_\_\_\_ no  
Vitamix? \_\_\_\_\_ yes \_\_\_\_\_ no  
Blender? \_\_\_\_\_ yes \_\_\_\_\_ no

OTHER LIFESTYLE/NUTRITION/ENVIRONMENTAL QUESTIONS

10. What do you juice and how often?

N/A

What? \_\_\_\_\_  
What? \_\_\_\_\_  
What? \_\_\_\_\_  
What? \_\_\_\_\_

How often? \_\_\_\_\_  
How often? \_\_\_\_\_  
How often? \_\_\_\_\_  
How often? \_\_\_\_\_

11. What do you blend/Vitamix and how often?

N/A

What? \_\_\_\_\_  
What? \_\_\_\_\_  
What? \_\_\_\_\_  
What? \_\_\_\_\_

How often? \_\_\_\_\_  
How often? \_\_\_\_\_  
How often? \_\_\_\_\_  
How often? \_\_\_\_\_

12. How many times per week do you practice Yoga? \_\_\_\_\_ Types: \_\_\_\_\_  
How many times per week do you practice Tai Chi? \_\_\_\_\_  
How many times per week do you practice Qi Gong? \_\_\_\_\_

13. Have you taken Repeated Rounds of:

\_\_\_\_\_ antibiotics When? \_\_\_\_\_  
\_\_\_\_\_ steroids When? \_\_\_\_\_  
\_\_\_\_\_ birth control pills When? \_\_\_\_\_

14. Do you shower or take baths in regular tap water? \_\_\_\_\_ yes \_\_\_\_\_ no  
How many times per week do you bath? \_\_\_\_\_  
How many times per week do you shower? \_\_\_\_\_

15. Are you now or have you been subjected to any Environmental Pollution?

\_\_\_\_\_ chemicals at work  
\_\_\_\_\_ chemicals at home  
\_\_\_\_\_ mold  
\_\_\_\_\_ mildew  
\_\_\_\_\_ dust  
\_\_\_\_\_ automobile exhaust  
\_\_\_\_\_ second hand cigarette smoke

16. What percentage of food and liquid that you consume is Organic?

\_\_\_\_0% \_\_\_\_10% \_\_\_\_20% \_\_\_\_30% \_\_\_\_40% \_\_\_\_50% \_\_\_\_60% \_\_\_\_70% \_\_\_\_80% \_\_\_\_90% \_\_\_\_100%

OTHER LIFESTYLE/NUTRITION/ENVIRONMENTAL QUESTIONS

On a scale of 1 to 10 (1 being very little/none, 10 being very much/a lot), please answer the following questions by circling your selection (number):

1. How much do you have difficulty sleeping soundly or going to sleep?  
Circle one: 1 2 3 4 5 6 7 8 9 10
  
2. How much do you wake up feeling exhausted?  
Circle one: 1 2 3 4 5 6 7 8 9 10
  
3. How much and often do you feel tired and fatigued during waking hours?  
Circle one: 1 2 3 4 5 6 7 8 9 10
  
4. How much do you feel your Health Challenges are related to Emotional/Mental Imbalances?  
Circle one: 1 2 3 4 5 6 7 8 9 10
  
5. How much do you have people in your life who will listen to you talk about your problems?  
Circle one: 1 2 3 4 5 6 7 8 9 10
  
6. How much are you supported/believed in by other people in your life?  
Circle one: 1 2 3 4 5 6 7 8 9 10
  
7. How much do you feel isolated or lonely?  
Circle one: 1 2 3 4 5 6 7 8 9 10
  
8. How much do you believe you can overcome your Health Challenges?  
Circle one: 1 2 3 4 5 6 7 8 9 10
  
9. How much do you desire (want to) and are willing to work at overcoming your Health Challenges?  
Circle one: 1 2 3 4 5 6 7 8 9 10

## OTHER LIFESTYLE/NUTRITION/ENVIRONMENTAL QUESTIONS

10. What seeming circumstances in your life (right now) might hinder you from making all the necessary

changes to Regain and Maintain your Health?

**Family Challenges**

Circle one: 1 2 3 4 5 6 7 8 9 10

**Financial Limitations**

Circle one: 1 2 3 4 5 6 7 8 9 10

**Emotional Problems**

Circle one: 1 2 3 4 5 6 7 8 9 10

**Support System Lacking**

Circle one: 1 2 3 4 5 6 7 8 9 10

11. How much do you eat Fast Food?

Circle one: 1 2 3 4 5 6 7 8 9 10

12. How much do you eat Junk Food?

Circle one: 1 2 3 4 5 6 7 8 9 10

13. If taking medication, how much do you desire to eliminate or reduce your need for medication?

Circle one: 1 2 3 4 5 6 7 8 9 10

14. How much do you know about Preventive Medicine Principles, Alternative Holistic Approaches to healing, Diet, Nutrition, Lifestyle, Environment, etc.?

Circle one: 1 2 3 4 5 6 7 8 9 10

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your Country Of Origin \_\_\_\_\_

Parent's Country Of Origin: Mother \_\_\_\_\_ Father \_\_\_\_\_

List All Areas Where You Lived Or Traveled To: \_\_\_\_\_

Do You Travel Frequently? \_\_\_\_\_

Do You Live In: \_\_\_\_\_ House \_\_\_\_\_ Apt. \_\_\_\_\_ Condo \_\_\_\_\_ Mobile Home \_\_\_\_\_ Prefab Home \_\_\_\_\_ Other \_\_\_\_\_

Approximate Age of Bldg: \_\_\_\_\_

Type of Construction: (Wood, Brick, Etc.) \_\_\_\_\_

Live With Another Person? \_\_\_\_\_ Yes \_\_\_\_\_ No; General Health of Other? \_\_\_\_\_

Do You Currently Live In: \_\_\_\_\_ City \_\_\_\_\_ Suburbs \_\_\_\_\_ Country \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Previous Occupations (If different From Current): \_\_\_\_\_

Please List Your Four Major Health Complaints In Order Of Importance And Indicate How Long You Have Had The Problem:

1. 3.

2. 4.

What Are Your Goals In Terms of Health?

Are You Willing To Make Changes/Adjustments In Your Life-Style To Reach Your Desired Health Goals?

**FAMILY HISTORY:**

Please Circle All Answers:

	Age Health If Living	Age Cause If Deceased	Has any blood relative ever had:	Please encircle No or Yes	Who				
					M	F	B	S	GP
Father Or			Cancer	No Yes					
Mother Or			Tuberculosis	No Yes					
Brother or Sister	1.		Diabetes	No Yes					
	2.		Heart Disease	No Yes					
	3.		High blood Pressure	No Yes					
	4.		Stroke	No Yes					
	5.		Heart Attacks	No Yes					
Husband or Wife			Mental/ Emotional Difficulties	No Yes					
Son or Daughter	1.		Arthritis	No Yes					
	2.		Multiple Sclerosis	No Yes					
	3.		Severe Skin Condition	No Yes					
	4.		Thyroid disease Dysfunction	No Yes					
	5.		Birth Defects	No Yes					
	6.		Eating/Weight disorders	No Yes					

**PERSONAL HEALTH HISTORY:**

Childhood Illnesses \_\_\_ Measles \_\_\_ Mumps \_\_\_ Chicken Pox \_\_\_ Whooping Cough \_\_\_ Other

Were You Vaccinated As A Child? \_\_\_\_\_ Yes \_\_\_\_\_ No What For \_\_\_\_\_

Were You Prone to Infection As a Child? \_\_\_\_\_ Yes \_\_\_\_\_ No Type: \_\_\_\_\_

**DENTAL HEALTH: Do You Have or Have You Had Any Of The Following?**

Gum Disease/Bleeding Periodontal Disease (Pyorrhea)

Tooth Extraction      Mouth Ulcers  
 Dental Amalgams (Fillings)      TMJ Syndrome/Pain  
 Crowns Increased Salivation  
 Bridges Metallic Taste  
 Dentures      Excessive Cavities/Decay  
 Implants      Sensitive Teeth  
 Root Canal      Bad Breath  
 Braces/Appliances      Burning Sensation In Mouth Or Tongue  
 Dental Surgery

Do You See A Dentist Regularly?     Yes     No  
 Do You Have Mercury Amalgam ("Silver") fillings in your mouth?     Yes     No  
 Do You Have or Have You Ever Had An Eating Disorder?     Yes     No    If Yes, What Type

What Personal Care/Hygiene Products Do You Use?     Natural     Man-Made

Are You Allergic To Any Pharmaceuticals Or Natural Remedies? Please List: \_\_\_\_\_

**Check The Following Conditions You Have Had:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> HIV                 | <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Anemia                   |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Arteriosclerosis     | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bladder disease      | <input type="checkbox"/> Bone or joint disease    |
| <input type="checkbox"/> Bursitis            | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Candida                  |
| <input type="checkbox"/> Colitis/bowel dis.  | <input type="checkbox"/> Chorea               | <input type="checkbox"/> Cold sores               |
| <input type="checkbox"/> Eczema              | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diphtheria               |
| <input type="checkbox"/> Fever blisters      | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Epilepsy                 |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Food, chemical       | <input type="checkbox"/> Frequent boils/infection |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Drug poisoning       | <input type="checkbox"/> German measles           |
| <input type="checkbox"/> Gout                | <input type="checkbox"/> Goiter               | <input type="checkbox"/> Gonorrhea                |
| <input type="checkbox"/> Hemorrhoids         | <input type="checkbox"/> Hay fever            | <input type="checkbox"/> Heart disease            |
| <input type="checkbox"/> High blood pres.    | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Herpes                   |
| <input type="checkbox"/> Intestinal worms    | <input type="checkbox"/> Hives                | <input type="checkbox"/> Influenza                |
| <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Kidney Stones            |
| <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Malaria              | <input type="checkbox"/> Miscarriage              |
| <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Migraine headaches   | <input type="checkbox"/> Nephritis                |
| <input type="checkbox"/> Nervous breakdown   | <input type="checkbox"/> Neuralgia            | <input type="checkbox"/> Neuritis                 |
| <input type="checkbox"/> Pancreas disease    | <input type="checkbox"/> Pleurisy             | <input type="checkbox"/> Pneumonia                |
| <input type="checkbox"/> Polio               | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psoriasis                |
| <input type="checkbox"/> Sciatica            | <input type="checkbox"/> Sickle Cell Disease  | <input type="checkbox"/> Rectal disease           |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Thyroid problems     | <input type="checkbox"/> Smallpox                 |
| <input type="checkbox"/> Thyroid fever       | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Venereal disease    |   | <input type="checkbox"/> Urinary stones           |

What Other Permanent Disease Conditions Have You Been Diagnosed With?

Types of Treatments You Have Had in the past and for What Conditions:

Do You Believe That These Diagnoses Are Accurate? If Not, Why Not?

What Do You "Feel" or "Think" Is Wrong with You \_\_\_\_\_

Do You Get Regular Check-ups?     Yes     No

Major Illnesses and  
Approximate Age/Dates:

Surgery and Approximate Dates  
(Including Dental Surgery):

Ages:

0-10 Yrs.	

10-20 Yrs.	
20-30 Yrs.	
30-40 Yrs.	
40-50 Yrs.	
50-60 Yrs.	
Over 60 Yrs.	

Additional Information (If Needed)

Current/recent Medications:

<u>Drug (Current)</u>	<u>Dose</u>	<u>Frequency</u>	<u>Drug (Current)</u>	<u>Dose</u>	<u>Frequency</u>
1.	6.				
2.	7.				
3.	8.				
4.	9.				
5.	10.				

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**REVIEW OF SYSTEMS**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Do you now have or have you had within the past year:  
Please circle all answers.

General:

Weight change \_\_\_\_\_ No Yes  
Fever/Chills \_\_\_\_\_ No Yes  
Dizziness \_\_\_\_\_ No Yes

Night Sweats \_\_\_\_\_ No Yes  
Tiredness without apparent reason \_\_\_\_\_ No Yes

Endocrine system:

Heat/Cold intolerance \_\_\_\_\_ No Yes  
Thyroid problems \_\_\_\_\_ No Yes  
Inability to stand heat \_\_\_\_\_ No Yes  
Excessive hunger \_\_\_\_\_ No Yes

Low blood sugar \_\_\_\_\_ No Yes  
Hot flashes \_\_\_\_\_ No Yes  
Inability to stand cold \_\_\_\_\_ No Yes  
Excessive thirst \_\_\_\_\_ No Yes

Eye:

Blurred vision \_\_\_\_\_ No Yes  
Double vision \_\_\_\_\_ No Yes  
Spots before the eyes \_\_\_\_\_ No Yes  
Do you wear glasses \_\_\_\_\_ No Yes  
When last checked \_\_\_\_\_

Red eye \_\_\_\_\_ No Yes  
Pain behind eyes \_\_\_\_\_ No Yes  
Any change in vision \_\_\_\_\_ No Yes  
Far sightedness \_\_\_\_\_ No Yes  
Near sightedness \_\_\_\_\_ No Yes  
Eye color: \_\_\_\_\_

Ear, Nose, Throat:

Decrease in hearing \_\_\_\_\_ No Yes  
Ringing in ears \_\_\_\_\_ No Yes  
Recurrent ear aches \_\_\_\_\_ No Yes  
Recurrent nose Bleeds \_\_\_\_\_ No Yes  
Persistent hoarseness \_\_\_\_\_ No Yes  
Strange persistent odors \_\_\_\_\_ No Yes  
Loss of smell \_\_\_\_\_ No Yes

Discharge from ears \_\_\_\_\_ No Yes  
Pressure in ears \_\_\_\_\_ No Yes  
Recurrent head colds \_\_\_\_\_ No Yes  
Sinus trouble \_\_\_\_\_ No Yes  
Growth in neck \_\_\_\_\_ No Yes  
Strange taste or loss in taste \_\_\_\_\_ No Yes

Gastrointestinal System:

Nausea or vomiting \_\_\_\_\_ No Yes  
Vomited blood \_\_\_\_\_ No Yes

Bad breath \_\_\_\_\_ No Yes  
Recurrent mouth sores \_\_\_\_\_ No

Difficulty swallowing \_\_\_\_\_ No Yes  
Difficulty in digestion \_\_\_\_\_ No Yes  
Recurrent stomach pain \_\_\_\_\_ No Yes  
Appetite: Good [ ] Fair [ ] Bad [ ]  
Avoid some foods \_\_\_\_\_ No Yes

Soreness/bleeding of gums on brushing \_\_\_\_\_ No Yes  
Belching or heartburn relieved by food or \_\_\_\_\_ No Yes  
Medication \_\_\_\_\_ No Yes  
Abdominal cramping \_\_\_\_\_ No Yes  
Intestinal worms \_\_\_\_\_ No Yes  
Peptic ulcer disease \_\_\_\_\_ No Yes  
Constipation \_\_\_\_\_ No Yes  
Dark or tarry BM \_\_\_\_\_ No Yes  
Rectal pain with BM \_\_\_\_\_ No Yes  
Abdominal swelling \_\_\_\_\_ No Yes

What kinds: \_\_\_\_\_

Diarrhea \_\_\_\_\_ No Yes  
Color of bowel movement \_\_\_\_\_  
Rectal bleeding \_\_\_\_\_ No Yes  
Change in size, shape or texture of BM \_\_\_\_\_ No Yes

REVIEW OF SYSTEMS

Pulmonary System:

Chronic/frequent cough \_\_\_\_\_ No Yes  
Cough up phlegm \_\_\_\_\_ No Yes

Difficulty/frequent cough \_\_\_\_\_ No Yes  
Shortness of breath on: \_\_\_\_\_

Cough up blood \_\_\_\_\_ No Yes  
 Tuberculosis exposure \_\_\_\_\_ No Yes  
 Respiratory infections/pneumonia No Yes  
 Wheezing \_\_\_\_\_ No Yes

Walking several blocks \_\_\_\_\_ No Yes  
 One flight of stairs \_\_\_\_\_ No Yes  
 On laying down \_\_\_\_\_ No Yes  
 Purple lips/fingers \_\_\_\_\_ No Yes  
 Do you smoke \_\_\_\_\_ No Yes  
 How many per day? \_\_\_\_\_

Cardiovascular

Do you exercise reg. \_\_\_\_\_ No Yes  
 Chest discomfort/pain \_\_\_\_\_ No Yes  
 Rapid heart beat \_\_\_\_\_ No Yes  
 Slow heart beat \_\_\_\_\_ No Yes  
 Skipped heart beats \_\_\_\_\_ No Yes  
 High blood pressure \_\_\_\_\_ No Yes  
 Leg cramps on walking or at night \_\_\_ No Yes

Enlarged veins in legs \_\_\_\_\_ No Yes  
 How many pillows do you use \_\_\_\_\_  
 Chronic/frequent cough on lying down \_\_\_ No Yes  
 Angina pectoris \_\_\_\_\_ No Yes  
 Wake up at night short of breath \_\_\_ No Yes  
 Swelling of hands, feet or ankles \_\_\_ No Yes

Genitourinary System:

Pain on urinating \_\_\_\_\_ No Yes  
 Urinate more than before \_\_\_\_\_ No Yes  
 Do you get up at night to urinate \_\_\_ No Yes  
 How many times? \_\_\_\_\_  
 Lose urine on coughing or sneezing \_\_\_ No Yes  
 Sex entirely satisfactory \_\_\_\_\_ No Yes  
 Any blood or pus in urine \_\_\_\_\_ No Yes  
 Difficulty in starting urination \_\_\_\_\_ No Yes  
 Urinate less than before \_\_\_\_\_ No Yes  
 How many times per day do you urinate \_\_\_\_\_  
 Full feeling of bladder, but only  
 small amount of urination \_\_\_\_\_ No Yes  
 Bed wetting \_\_\_\_\_ No Yes

Skin

Complexion: \_\_\_ Exec. \_\_\_ Good \_\_\_ Fair \_\_\_ Poor  
 Rash \_\_\_\_\_ No Yes  
 Itching \_\_\_\_\_ No Yes  
 Mole (s) \_\_\_\_\_ No Yes  
 Hives or allergy \_\_\_\_\_ No Yes  
 Brittleness of nails \_\_\_\_\_ No Yes  
 Easy bruising \_\_\_\_\_ No Yes  
 Change in hair texture \_\_\_\_\_ No Yes  
 Changes in skin texture \_\_\_\_\_ No Yes  
 Dryness of Skin \_\_\_\_\_ No Yes  
 Natural Hair Color: \_\_\_ Black \_\_\_ Brown  
 \_\_\_ Red \_\_\_ Blond \_\_\_ Other

Breasts:

Breast lump \_\_\_\_\_ No Yes  
 Breast pain \_\_\_\_\_ No Yes  
 Nipple discharge \_\_\_\_\_ No Yes

Hematologic System

Excessive bleeding/bruising \_\_\_\_\_ No Yes  
 Anemia \_\_\_\_\_ No Yes  
 Have you ever had blood or plasma  
 transfusion \_\_\_\_\_ No Yes  
 Sickle Cell \_\_\_\_\_ No Yes  
 Like to eat ice, dirt \_\_\_\_\_ No Yes

For women only

Age at onset of first period \_\_\_\_\_ No Yes  
 Regular? \_\_\_\_\_ Varies \_\_\_\_\_ No Yes  
 Cycle \_\_\_\_\_ (Start from start)  
 Flow: Heavy \_\_\_ Medium \_\_\_ Light \_\_\_  
 Number of pads used per period \_\_\_\_\_  
 Any clots passed \_\_\_\_\_ No Yes  
 Pain or cramps \_\_\_\_\_ No Yes  
 Date of last period \_\_\_\_\_  
 Date of last pelvic exam \_\_\_\_\_  
 Date of last Pap test \_\_\_\_\_  
 Results: Neg \_\_\_\_\_ Pos \_\_\_\_\_

Musculoskeletal system

Joint stiffness \_\_\_\_\_ No Yes  
 Joint pain \_\_\_\_\_ No Yes  
 Swelling of any joints \_\_\_\_\_ No Yes  
 Redness/heat of joints \_\_\_\_\_ No Yes  
 Broken or cracked bones \_\_\_\_\_ No Yes  
 Sprains or dislocations \_\_\_\_\_ No Yes  
 Muscle spasms \_\_\_\_\_ No Yes  
 Neck pain/stiffness \_\_\_\_\_ No Yes  
 Back pain/stiffness \_\_\_\_\_ No Yes

REVIEW OF SYSTEMS

For women only cont.:

Any discharge from vagina \_\_\_\_\_ No Yes  
 If so color \_\_\_\_\_

For men only

Discharge from penis \_\_\_\_\_ No Yes  
 Burning urination \_\_\_\_\_ No Yes

Amount \_\_\_\_\_  
 Any itching of vaginal area \_\_\_\_\_ No Yes  
 Do you take birth control pills \_\_\_\_\_ No Yes  
 How long have you taken them \_\_\_\_\_  
**Pregnancies:**  
 How many children born alive \_\_\_\_\_  
 How many still births \_\_\_\_\_  
 How many premature births \_\_\_\_\_  
 How many Cesarean Sections \_\_\_\_\_  
 How many miscarriages \_\_\_\_\_  
 Any complications with pregnancy \_\_\_ No Yes  
 Describe \_\_\_\_\_  
 Other \_\_\_\_\_

Testicular mass/pain \_\_\_\_\_ No Yes  
 Prostate trouble \_\_\_\_\_ No Yes

***Psychological System : (Circle all that apply)***

Exhausted, tired, drained or  
 overwhelmed \_\_\_ No Yes  
 Pressured, tense or stressed \_\_\_ No Yes  
 Nervous, panicky, worried,  
 anxious or fearful \_\_\_ No Yes  
 Annoyed, irritable, resentful  
 or angry \_\_\_ No Yes  
 Frustrated \_\_\_\_\_ No Yes  
 Bored, unmotivated or  
 Uninterested \_\_\_ No Yes  
 Inadequate or inferior \_\_\_\_\_ No Yes  
 Guilty or ashamed \_\_\_\_\_ No Yes  
 Lonely, unloved or alone \_\_\_\_\_ No Yes  
 Sad or depressed \_\_\_\_\_ No Yes  
 Hopeless or discouraged \_\_\_\_\_ No Yes  
 Alcohol or drug abuse \_\_\_\_\_ No Yes

**Neurological System**

Frequent or severe headaches \_\_\_\_\_ No Yes  
 Epileptic seizures/convulsions \_\_\_\_\_ No Yes  
 Tingling or weakness of hands/feet \_\_\_ No Yes  
 Loss or change in sensation of hands/feet \_\_\_ No Yes  
 Fainting spells \_\_\_\_\_ No Yes  
 Weakness \_\_\_\_\_ No Yes  
 Stroke \_\_\_\_\_ No Yes

**Current/recent medications:**

<u>Drug (current)</u>	<u>Dose</u>	<u>Frequency</u>	<u>Drug (current)</u>	<u>Dose</u>	<u>Frequency</u>
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

**Types of Diagnostic Tests You Have Had In The Past:**

\_\_\_\_\_ Blood/Urine    \_\_\_\_\_ X-rays    \_\_\_\_\_ MRI    \_\_\_\_\_ CT scan    \_\_\_\_\_ EKG/Exercise Stress Test  
 \_\_\_\_\_ Other (Explain) \_\_\_\_\_

Have Any Of The Above Test Results Been Abnormal? Which: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_