

**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	Daily	or	Weekly	Number of times	
_____ Milk _____ Goat _____ Human	_____ Low fat _____ Whole _____ 1%					
_____ Juice _____ Vegetable _____ Fruit	_____ Fresh _____ 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? \_\_\_\_\_

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

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

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

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

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

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

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

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

N/A

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

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

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

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

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

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

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

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 (Pyorrhoea)      |
| 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:**

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

<b>0-10 Yrs.</b>	
<b>10-20 Yrs.</b>	
<b>20-30 Yrs.</b>	
<b>30-40 Yrs.</b>	
<b>40-50 Yrs.</b>	
<b>50-60 Yrs.</b>	
<b>Over 60 Yrs.</b>	

**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.		