Center For New Medicine

## ACKNOWLEDGMENT AND CONSENT

I understand that the Center For New Medicine, Inc. may use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that the Center For New Medicine, Inc. may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how the Center For New Medicine, Inc. will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of the Center For New Medicine, Inc., and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of the Center For New Medicine, Inc.'s Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that the Center For New Medicine, Inc. is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

By: ______________________________ ______________________ Date: _________________
Print Patient Name                 Signature

- OR -

By: ______________________________ ______________________ Date: _________________
Patient representative-Print        Signature

Description of Representative's Authority: ______________________________________________

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CENTER FOR NEW MEDICINE

I, ________________________________________ understand that if I am seen by a doctor and have my blood drawn at the same visit, there will be a separate $20 fee for the drawing of my blood that our office does not bill to insurance.

If I come in on a separate visit just for a blood draw, I understand that I will have a co-payment and / or an amount due from my deductible to the Center for New Medicine's office for the drawing of my blood. I also understand that I will receive a bill from the laboratory that is processing my blood work/urinalysis.

I understand that not all labs are contracted with all insurance companies, and we make every effort to verify contracted lab information. However, since labs and contracts change constantly, you are welcome to:

1. Request a lab slip and call your insurance company for current information, then go to a contracted lab directly for the blood draw/urinalysis.
   *OR*
2. Ask that we send your lab work to Westcliff Laboratories. We have an agreement with Westcliff that they will take the contracted discount for all lab work, regardless of network status, if you call them when you receive your statement and request this service.

________________________________________ ________________________
Patient signature (or parent, if patient is a minor) Date

________________________________________________________________
Witnessed

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# NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage,
- Billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

CENTER FOR NEW MEDICINE

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Mary Ann Spreeman
Center for New Medicine, Inc.
6 Hughes St. Suite 100
Irvine, CA 92618
(949) 680 - 1880

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

# ARBITRATION AGREEMENT

**Article 1** It is understood that any dispute or claim against Center for New Medicine and/or the "Clinic" as defined herein whether for malpractice of any kind, and any other claims of any nature whatsoever including, but not limited to, any type of tort or contract, that were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, action or inaction, failure to act, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2** a) The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

"Clinic" includes Center for New Medicine, Oasis of Hope, all doctors, their professional corporation or partnership, all independent contractors who practice or provide service for Center for New Medicine, all employees, representatives, agents, directors, officers and assignees of Center for New Medicine, and any employees agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities.

b) Actions Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Clinic and Patient will be subject to compulsory, binding arbitration.

c) Other Doctors, Medical Professionals, Service Providers, Dental Providers and/or Care Professionals. Patient understands that he or she may at times receive treatment from one or more Doctors, Medical Professional, Service Providers, Dental Providers or other type of Care Professional who are independent contractors practicing or providing services at the same facility at Center for New Medicine. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such providers providing any type of service at the same facility and/or Center for New Medicine will be subject to compulsory, binding arbitration.

d) Right of Action Waived. Patient understands that a claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein.

**Article 3** a) Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the care rendered by Center for New Medicine and/or Clinic to Patient, Patient will promptly notify Center for New Medicine and/or Clinic so that Center for New Medicine and/or Clinic may have the opportunity to resolve the matter

b) Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement, Patient shall notify Center for New Medicine and the Clinic in writing of his or her desire to arbitrate and shall designate an arbitrator. Within receipt of such notice, Center for New Medicine and Clinic will designate an arbitrator to act on the parties' behalf in the event Patient actually files a claim for arbitration and pays the applicable required arbitration fees.

c) Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P 1280-1295). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California including the provisions of the medical Injury Compensation Reform Act of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d) Interpretation of Agreement. Any controversy concerning the interpretation or application of the Agreement itself shall also be submitted to arbitration in the manner provided above.

**Article 4** Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give the Clinic written notice within 30 days from signing that you want to withdraw from the Agreement. However, Clinic and Patient agree that any claim arising from services rendered prior to revocation shall be subject to arbitration.

**Article 5: Retroactive Effect**: Also, by executing the agreement Patient agrees that this agreement covers ALL services rendered as defined in Article 1 before the date this agreement is signed whatever date the service was rendered.

**Article 6:** Invalid Provisions. If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ACTION OR REQUEST FOR DAMAGES DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT**

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

By: ______________________________ ______________________________ __________

Patient's or Patient Representative's Signature | Patient's Printed Name | Date

Duly Consented by Center for New Medicine and Clinic. ________________Leigh Erin Connealy MD, Medical Director

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## POLICIES FOR CONTACT WITH OUR OFFICE

The following policies are designed to give you the best experience possible when contacting us between visits. We want our communications with you to be easy and enjoyable. We usually return calls, faxes and e-mails the same day, but please understand it if takes a bit longer.

**Fax: (949) 680-1881**
This is the quickest way to get a response to short medical questions, or to receive prescription refills. If you fax us your question, we will usually be able to respond within the day. However, if the question is too complicated to be answered with a faxed response, our reception will contact you to schedule a phone consult with one of the practitioners.

**Phone: (949) 680-1880**
We answer our phones from 8:30am-12:00pm and 2:00pm-5:00pm Monday through Thursday, and 8:00am-12:00pm on Friday. However, because the doctors are with clients during the day, they may be unable to speak with you directly at the time you call. Our reception staff will do their best to answer quick questions, but more complex ones will require a phone consult with a practitioner.

**E-mail: info@cfnmedicine.com**
E-mail is answered within 1 working day of receipt, but is best suited for administrative concerns. Because the doctors are very busy during the day, medical questions sent via e-mail may take longer for a response than those sent by fax.

**Prescription Refills**
We fill prescriptions during regular office hours. Feel free to have your pharmacy fax a refill request to us, or you may fax it yourself. If you fax it yourself, please include the fax number of your pharmacy. We ask that you do not use our after-hours answering service for prescription refills.

**Contacting Us After Business Hours Or On Weekends**
If you have a true emergency or feel that you must reach us outside of normal business hours, please use our answering service. You can reach our answering service by calling our phone number and following the voice prompts. However, if your concern is not urgent, we request that you wait until normal business hours.

Periodically, it becomes necessary for us to leave personal health information such as lab or x-ray test results by telephone after we have been unable to reach you after several attempts. By indicating your permission here, we will leave the information at your current home telephone answering machine or voice mail. Please make sure to keep your phone number updated in our data base records.

- ☐ I authorize leaving message on my home voice mail or answering machine
- ☐ I **do not** authorize leaving messages on my home voice mail or answering machine.

If you want the information left at a different location, it will be necessary for you to indicate that very plainly to a member of our office staff.

***I have read, understand and agree to the provisions of this office policy.***

_________________________________________     ____________________________

*Signature of Patient (or parent if patient is a minor)*     *Date*

_________________________________________

*Print Name*

Center For New Medicine, Inc.
6 Hughes, Suite 100 * Irvine, CA 92618
Phone: (949) 680-1880 * Fax: (949) 680-1881

# PATIENT MEDICAL HISTORY

**Patient Name:**______________________________ **Date:** ______________

**Weight:** Present ________ Desired ________ 1 Yr. Ago ________ 5 Yrs. Ago ________

| PAST MEDICAL HISTORY | DATES |
|---|---|
| Anemia or history of blood transfusion | |
| Autoimmune disorder (SLE, Graves,etc.) | |
| Cancer (describe) | |
| Candida - Yeast infection -Thrush | |
| CFS or Fibromyalgia | |
| Diabetes | |
| Fatigue (describe; under what conditions) | |
| Fever or frequent infections | |
| Generalized weakness | |
| Heart Disease | |
| Hepatitis | |
| High Blood Pressure | |
| HIV / AIDS | |
| Hormone imbalance (see page 4) | |
| Pain / aching | |
| Where: | |
| Describe (sharp, dull, etc.) | |
| How long: | |
| Under what conditions: | |
| Rheumatic Fever | |
| Seizures | |
| Swollen glands | |
| Thyroid disease | |
| Other (any hospitalizations): | |

| FAMILY MEDICAL HISTORY | WHICH RELATIVE |
|---|---|
| Cancer | |
| Diabetes | |
| Heart attack or heart disease | |
| Hepatitis or Liver disease | |
| High Blood Pressure | |
| HIV/AIDS | |
| Obesity | |
| Seizures | |
| Thyroid disease | |
| Dementia/Alzheimer's | |
| High Cholesterol | |

| PERSONAL HABITS | | |
|---|---|---|
| Smoke packs/day | | |
| Quit smoking years ago | | |
| Chew tobacco | Yes | No |
| Coffee cups/day | | |
| Tea cups/day | | |
| Carbonated beverages /day | | |
| Water /day | | |
| Drink alcohol | Yes | No |
| If yes: Daily Frequently Occasionally Rarely (circle one) | | |
| Recreational drugs or marijuana | Yes | No |
| Alcoholism | Yes | No |
| Wear nail polish | Yes | No |
| Wear acrylic nails | Yes | No |
| Use cosmetics | Yes | No |
| Get regular exercise | Yes | No |
| Type: How often: | | |
| Hours of sleep nightly: | | |
| How often you get up at night: | | |
| Sleep aids: | | |
| Hours worked per week: | | |
| What you do to relax: | | |
| Spirituality: Do you pray? Meditate? Practice Yoga? Other? | | |

| X-RAYS, Scans & Endoscopy | DATES |
|---|---|
| Abdomen | |
| Back | |
| Chest | |
| Colon | |
| Extremities | |
| Full Body Scan/Heart Scan | |
| Gallbladder | |
| Kidney | |
| CT Scan or MRI of: | |
| Endoscopy of Colonoscopy: | |

| SURGERIES / ORGANS REMOVED | DATES |
|---|---|
| | |
| | |
| | |
| | |

| SIGNIFICANT TRAUMA (accidents, falls, etc.) | DATES |
|---|---|
| | |
| | |
| | |
| | |

| DENTAL | DATES |
|---|---|
| Metal amalgam fillings | |
| If removed, when: | |
| TMJ (clenching, grinding) | |
| Snoring/sleep apnea | |
| Root canals | |
| Wisdom teeth extracted | |
| Crowns / caps | |
| Material used: | |
| Braces / retainer | |
| Sensitive teeth / sensitive gums | |
| Dentures | |
| Last dental cleaning | |
| Last dental exam | |
| Last dental images (x-rays) | |
| Dental Problems | |
| Other: | |

| ALLERGIES / SENSITIVITIES | | |
|---|---|---|
| Carpet / furniture / cabinets | Yes | No |
| Chemicals | Yes | No |
| Cologne smells like bug spray | Yes | No |
| Cologne, scented products | Yes | No |
| Dust | Yes | No |
| Fabric | Yes | No |
| Foods | Yes | No |
| List: | | |
| Metals | Yes | No |
| Mold | Yes | No |
| Pesticides, fumigation | Yes | No |
| Pollen | Yes | No |
| Smoke | Yes | No |
| Suspect you're allergic but don't know to what | Yes | No |
| Other allergies: | Yes | No |
| List: | | |
| | | |
| | | |
| | | |



Revised 8/3/2009

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# PATIENT MEDICAL HISTORY

**Patient Name:**________________________________ **Date:** ______________

| GENERAL | | | | | |
|---|---|---|---|---|---|
| Cold Feet | Yes | No | Chills | Yes | No |
| Cold Hands | Yes | No | Dizziness (vertigo) | Yes | No |
| Cravings | Yes | No | Fatigue | Yes | No |
| Excess sleep | Yes | No | Fevers | Yes | No |
| Excessive thirst (mouth feels like cotton) | Yes | No | Night Sweats | Yes | No |
| Heavy Appetite | Yes | No | Poor heat / cold tolerance | Yes | No |
| Insomnia | Yes | No | Rarely sweat | Yes | No |
| Low blood sugar | Yes | No | Sudden energy drop (time: ) | Yes | No |
| Peculiar tastes/smells | Yes | No | Sweat easily | Yes | No |
| Poor Appetite | Yes | No | Tired upon awakening in morming (feel like you haven't slept) | Yes | No |
| Poor / restless sleep | Yes | No | Other | | |

| SKIN & HAIR | | | | | |
|---|---|---|---|---|---|
| Acne / pimples | Yes | No | | | |
| Athlete's foot | Yes | No | Brittle nails | Yes | No |
| Burning on bottom of feet | Yes | No | Bruise easily | Yes | No |
| Change in hair/skin texture | Yes | No | Cuts heal slowly | Yes | No |
| Changing moles Where: | Yes | No | Dandruff | Yes | No |
| Crawling sensation | Yes | No | Eczema | Yes | No |
| Dry skin | Yes | No | Hair loss (crown, front, sides, hair line, back; diffuse; sudden) | Yes | No |
| Flushing | Yes | No | Nail fungus | Yes | No |
| Hives | Yes | No | Peeling or cracking skin on feet | Yes | No |
| Itching | Yes | No | Psoriasis | Yes | No |
| Oily skin | Yes | No | Split or ridged nails | Yes | No |
| Rashes | Yes | No | Sweating | Yes | No |
| Pale skin | Yes | No | White spots on nails | Yes | No |
| Pigmentation / brown spots | Yes | No | Other hair/skin problems: | Yes | No |
| Other: | | | | | |

| EYES, EARS, NOSE & THROAT | | | | | |
|---|---|---|---|---|---|
| Blindness or decreased vision | Yes | No | Excessive mucous | Yes | No |
| Bright flashes | Yes | No | Hay fever | Yes | No |
| Cataracts | Yes | No | Nasal polyps | Yes | No |
| Color blindness | Yes | No | Nose bleeds | Yes | No |
| Blurred / tunnel vision | Yes | No | Runny nose | Yes | No |
| Contact lenses | Yes | No | Sinus problems | Yes | No |
| Dark circles under eyes | Yes | No | Sneezing attacks | Yes | No |
| Eye pain | Yes | No | Stuffy nose | Yes | No |
| Eye strain | Yes | No | | | |
| Floaters in eyes | Yes | No | Bleeding gums | Yes | No |
| Glaucoma | Yes | No | Canker sores | Yes | No |
| Gritty feeling in eyes/dry eyes | Yes | No | Chronic coughing | Yes | No |
| Halos around lights | Yes | No | Cold sores | Yes | No |
| Poor night vision | Yes | No | Cracking around lips / white tongue | Yes | No |
| Sensitive to sunlight or strong light | Yes | No | | | |
| Swollen, reddened or sticky eyelids | Yes | No | Frequent sore throats | Yes | No |
| Watery, itchy eyes | Yes | No | Enlarged glands | Yes | No |
| Wear sunglasses | Yes | No | Gagging, frequent need to clear throat | Yes | No |
| | | | Grinding teeth | Yes | No |
| Deafness | Yes | No | Hoarseness | Yes | No |
| Drainage from ears | Yes | No | Discoloration of gums | Yes | No |
| Earaches, ear infections | Yes | No | Other gum problems | Yes | No |
| Hearing aides | Yes | No | Swallowing difficulty | Yes | No |
| Hearing loss | Yes | No | Swollen or discolored tongue, gums, lips | Yes | No |
| Itching in ear canal | Yes | No | TMJ problems | Yes | No |
| Itching/redness wearing earrings | Yes | No | Tonsillitis | Yes | No |
| Ringing or buzzing in ears | Yes | No | Other: | | |
| | | | | | |

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# PATIENT MEDICAL HISTORY

**Patient Name:**_______________________________________________ **Date:** ________

| CARDIOVASCULAR | | | | | |
|---|---|---|---|---|---|
| Abnormal electrocardiogram (EKG) | Yes | No | High cholesterol | Yes | No |
| Angina (heart / chest pain) | Yes | No | Irregular/skipped heartbeats or palpatations | Yes | No |
| Awaken from sleep with shortness of breath | Yes | No | Low blood pressure | Yes | No |
| Blood clots | Yes | No | Numbness of hands / feet | Yes | No |
| Coronary Heart Scan (calcium score) | Yes | No | Pacemaker | Yes | No |
| Difficulty breathing | Yes | No | Phlebitis | Yes | No |
| Enlarged heart | Yes | No | Rapid heartbeats | Yes | No |
| Fainting | Yes | No | Swollen hands / feet | Yes | No |
| Heart attack | Yes | No | Varicose veins | Yes | No |
| Heart murmur | Yes | No | Echocardiogram (heart ultrasound) | Yes | No |
| Heart surgery | Yes | No | Treadmill Stress Test | Yes | No |
| High blood pressure | Yes | No | Other: | Yes | No |
| Holter monitor | Yes | No | | | |

| RESPIRATORY | | | | | |
|---|---|---|---|---|---|
| Allergies | Yes | No | Abnormal chest x-ray | Yes | No |
| Asthma | Yes | No | History of Bronchitis | Yes | No |
| Cough | Yes | No | Bronchietasis | Yes | No |
| Coughing blood | Yes | No | Cystic fibrosis | Yes | No |
| Difficulty breathing | Yes | No | Chest congestion | Yes | No |
| Low exercise tolerance | Yes | No | COPD or Emphysema | Yes | No |
| Pain with deep breathing | Yes | No | History of Pneumonia | Yes | No |
| Shortness of breath with activity or at rest | Yes | No | Lung nodules or calcium deposits | Yes | No |
| Sleep apnea | Yes | No | Use inhalers or wheezing | Yes | No |
| Tuberculosis | Yes | No | Other: | | |

| GASTROINTESTINAL | | | | | |
|---|---|---|---|---|---|
| Abdominal pain/cramps | Yes | No | Hiatial hernia | Yes | No |
| Alternating constipation & diarrhea | Yes | No | Heartburn or GERD | Yes | No |
| History of Appendicitis | Yes | No | Hemorrhoids | Yes | No |
| Appetite - excessive | Yes | No | Indigestion | Yes | No |
| Appetite - poor | Yes | No | Nausea | Yes | No |
| Bad breath or bad taste in your mouth | Yes | No | Nervous stomach | Yes | No |
| Black or bloody stools | Yes | No | Parasites | Yes | No |
| Bloated feeling/abdominal distention | Yes | No | Persistent flatulence or gas | Yes | No |
| Bowel habit changes | Yes | No | Rectal bleeding | Yes | No |
| Colon or bowel trouble | Yes | No | Rectal itch or pain | Yes | No |
| Colon polyps | Yes | No | Sensitive abdomen | Yes | No |
| Constipation | Yes | No | Sweets upset | Yes | No |
| Crohn's or Ulcerative colitis | Yes | No | Ulcers | Yes | No |
| Diarrhea, persistent | Yes | No | Vomiting blood | Yes | No |
| Diverticulosis or Diverticulitis | Yes | No | Bowel movements (how often) per day | | |
| Frequent belching/flatulence or gas | Yes | No | Laxative use: per week; type | | |
| Gallbladder attacks or stones | Yes | No | Other: | | |
| Heliobacter pylori | Yes | No | | | |



Revised 8/3/2009

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# PATIENT MEDICAL HISTORY

**Patient Name:**________________________________________________ **Date:** _________

| GENITO-URINARY | | | | | |
|---|---|---|---|---|---|
| Frequent urination | Yes | No | Blood in urine | Yes | No |
| Interstitial cystitis | Yes | No | H/O kidney infections | Yes | No |
| Kidney pain (mid-back) | Yes | No | Kidney stones | Yes | No |
| Pain on urination | Yes | No | Sexually transmitted disease | Yes | No |
| Problem passing urine | Yes | No | List:: | | |
| Transgender (trans-female or trans-male) | Yes | No | | | |
| Trouble holding urine / incontinence | Yes | No | Wake up to urinate: How often /night | | |
| Urgency to urinate | Yes | No | Other: | | |

| MALE REPRODUCTIVE / GENITALIA | | | | | |
|---|---|---|---|---|---|
| Dimished sex desire | Yes | No | Premature ejaculation | Yes | No |
| Enlarged prostate gland | Yes | No | Sex drive decreased | Yes | No |
| Erection problems/Impotency | Yes | No | Sore or lesion on penis | Yes | No |
| Hernia | Yes | No | Where: | | |
| Lump in testicles | Yes | No | | | |
| Night time erections | Yes | No | Have you tried Viagra, Cialis or Levitra | Yes | No |
| Penis discharge | Yes | No | Have you tried testosterone | Yes | No |
| Peyroinne's disease (abnormal curvature of penis) | Yes | No | Other: | | |

| PREGNANCY & GYNECOLOGY | | | | | |
|---|---|---|---|---|---|
| Age of first menses (period): | | | Endometriosis | Yes | No |
| Number of pregnancies: Number of births: Miscarriages: | | | Fibroid Uterus | Yes | No |
| Tubal pregnancies: # | Yes | No | Hot flashes or night sweats | Yes | No |
| Flow: Heavy / light / clots (circle) | | | Infertility, difficulty getting pregnant | Yes | No |
| Period duration: | | | Irregular periods | Yes | No |
| Last mammogram: | | | Menstrual cramps or spotting | Yes | No |
| Last Pap Smear: Last menstrual cycle: | | | Nipple discharge or pain | | |
| Abnormal Pap When: | Yes | No | Pain with intercourse | Yes | No |
| If so what treatment (repeat pap, cryotherapy/freezing, or medication) | | | Pelvic pain | Yes | No |
| Birth control type: | Yes | No | PMS (moody, cravings, breast tenderness, bloating) | Yes | No |
| Hormone replacement: Which? | Yes | No | Ovarian cysts or PCOS | Yes | No |
| Menopause (date): | Yes | No | Vaginal discharge or itching | Yes | No |
| Last pelvic sonogram (ultrasound)? | Yes | No | Vaginal dryness | Yes | No |
| Breast lumps | Yes | No | Other: | | |
| Low sex drive | Yes | No | | | |

| MUSCULOSKELETAL | | | | | |
|---|---|---|---|---|---|
| Pain where: | | | Rheumatoid Arthritis | Yes | No |
| Stiffness where: | | | Joint swelling | Yes | No |
| Swelling where: | | | Muscle weakness, numbness or tingling | Yes | No |
| Enlarged knuckes or bumps on joints | Yes | No | Bump on bones | Yes | No |
| Where: | | | Damp weather causes aching | Yes | No |
| Head injury | Yes | No | Body or face not symmetrical | Yes | No |
| Concussion | Yes | No | Pain or popping in jaw | Yes | No |
| Whiplash | Yes | No | Sciatica | Yes | No |
| Low back stiffness | Yes | No | Joint pain: Where: | Yes | No |
| Loss of consciousness | Yes | No | Joint Surgery: Where: | Yes | No |
| Mobility problems | Yes | No | Do you use a cane? | Yes | No |
| Osteoporosis or Osteopenia | Yes | No | Other: | | |
| Tightness between shoulder blades | Yes | No | | | |

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# PATIENT MEDICAL HISTORY

**Patient Name:**______________________________ **Date:** ______________

| NEURO-PSYCHOLOGICAL | | | | | |
|---|---|---|---|---|---|
| Anger, irritability | Yes | No | Alzheimer's or Parkinson's | Yes | No |
| Anxiety, fear, nervousness (panic attacks) | Yes | No | Areas of numbness or tingling | Yes | No |
| Bipolar (elevated & depressed mood, addictions) | Yes | No | Where: | | |
| Concussions or blunt head trauma | Yes | No | Have you ever considered or attempted suicide | Yes | No |
| Confusion | Yes | No | Are you suicidal now | Yes | No |
| Cry often or easily | Yes | No | Have you seen a counsellor or psychiatrist | Yes | No |
| Depression | Yes | No | Multiple personality disorder | Yes | No |
| Do you want a referral for counselling | Yes | No | Mood swings | Yes | No |
| Do you have a family history of mental disorder(s) | Yes | No | Slurred speech | Yes | No |
| Drug addiction | Yes | No | Sense of despair or socially isolated | Yes | No |
| Easily stressed or overwhelmed | Yes | No | Stuttering, stammering | Yes | No |
| Eating disorder (Anorexia or Bulemia) | Yes | No | Learning disabilities (e.g. dyslexia) | Yes | No |
| Schizophrenia | Yes | No | Leg or arm weakness | Yes | No |
| Fatigue, sluggishness | Yes | No | Have you taken meds for anxiety or depression | Yes | No |
| Feel inferior | Yes | No | Phobias, irrational fears | Yes | No |
| Feel life is demanding / stressful | Yes | No | Poor concentration or coordination | Yes | No |
| Feel life is unsatisfactory | Yes | No | Strokes (mini-stroke or TIA) | Yes | No |
| Friends say you drink too much | Yes | No | Poor memory, forgetfulness | Yes | No |
| Hair loss | Yes | No | Restlessness | Yes | No |
| Have you been hospitalized for depression | Yes | No | Treatment for emotional problems | Yes | No |
| Headaches (Stress, Tension, Cluster or Migraines) | Yes | No | Tremors (shaking, twitching) | Yes | No |
| Where (front, back,sides) When: | Yes | No | Worry frequently | Yes | No |
| History of Seizures | Yes | No | Startled awake at night, nightmares or vivid dreams | Yes | No |
| Hyperactivity or ADD | Yes | No | Nervous break down | Yes | No |
| Insomnia (can't go to sleep or awaken from sleep) | Yes | No | | | |

| MEDICAL PROBLEMS NOT COVERED ELSEWHERE | | | | | |
|---|---|---|---|---|---|
| Recurrent skin infections | Yes | No | Obesity | Yes | No |
| Broken bones | Yes | No | Parasites | Yes | No |
| Cirrhosis or liver disease | Yes | No | Abnormal blood clotting | Yes | No |
| Gout | Yes | No | Polio | Yes | No |
| Goiter (enlarged thyroid) | Yes | No | Rheumatic fever | Yes | No |
| Mononucleosis | Yes | No | Slow metabolism | Yes | No |
| Drug reaction | Yes | No | Warts | Yes | No |
| Biopsies | Yes | No | Other: | | |

| ELECTROMAGNETIC RADIATION | | | | | |
|---|---|---|---|---|---|
| Frequent x-rays | Yes | No | Use a waterbed or electric blanket | Yes | No |
| Live under or near power lines | Yes | No | Work with computers | Yes | No |
| Use a cellular or portable phone | Yes | No | Other radiation exposure | Yes | No |
| Do you use an ear piece for your cell phone | Yes | No | Describe: | | |

| BIRTH FACTORS - "were you": | | | | | |
|---|---|---|---|---|---|
| Birth trauma (describe) | | | Is medical info available from birth parents | Yes | No |
| Bottle fed | Yes | No | Casarean section or forceps delivery | Yes | No |
| Breast fed | Yes | No | Premature | Yes | No |
| Adopted | Yes | No | Unknown | Yes | No |



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# PATIENT MEDICAL HISTORY

**Patient Name:**_______________________________________ **Date:** ____________________

## Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days

| Circle the corresponding number for questions a-e below | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | Never | 1 | Rarely | 2 | Monthly | 3 | Weekly | 4 | Daily |

| Question | | | | | |
|---|---|---|---|---|---|
| a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) | 0 | 1 | 2 | 3 | 4 |
| b. How often are pesticides used in your home? | 0 | 1 | 2 | 3 | 4 |
| c. How often so you have your home treated for insects? | 0 | 1 | 2 | 3 | 4 |
| d. How often are you exposed to nail polish, perfume, hair spray and other cosmetics? | 0 | 1 | 2 | 3 | 4 |
| e. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? | 0 | 1 | 2 | 3 | 4 |

| Circle the corresponding number for questions below | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0 | No | 1 | Mild Change | 2 | Moderate Change | 3 | Drastic Change |

| Question | | | | |
|---|---|---|---|---|
| Have you noticed any negative change in your health since you moved into your home or apartment? | 0 | 1 | 2 | 3 |
| Have you noticed any negative change in your health since you started your new job? | 0 | 1 | 2 | 3 |

| Question | | |
|---|---|---|
| Do you have a water purification system in your home? | Yes | No |
| Do you have any indoor pets ? | Yes | No |
| Do you have an air purification system in your home? | Yes | No |
| Are you a dentist, painter, farm worker or construction worker? | Yes | No |

**Describe your work history. Include exposure to chemicals, fumes, pesticides, metals,heavy lifting, electromagnetic fields, radiation, asbestos, high stress, and anything that may be health related.**

Dates: Description of work:

Dates: Description of work:

**Briefly describe where you have lived since childhood - part of country / world, in city / rural, etc., and potential exposures from ill patients unusual neighbors' occupations (cattle rearing, farming, raising pigeons or turtles) etc.**

**Describe your hobbies, sports, and forms of recreation, with attention to exposure as listed under work history:**

**Are you interested in a weight loss program?**

**What diets or weight loss programs have you tried and were you successful?**

**Is there anything else you would like us to know?**

**What is your biggest concern that you'd like to discuss today?**

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# PATIENT MEDICAL HISTORY

**Patient Name:**______________________________ **Date:** ________________

Circle the corresponding number for items below

| | |
|---|---|
| 0 | No or Never |
| 1 | Yes or Sometimes |
| 2 | Often |

## NUTRITIONAL

| Item | | | |
|---|---|---|---|
| Abnormal thirst | 0 | 1 | 2 |
| Appetite loss, anorexia | 0 | 1 | 2 |
| Avoid cruciferous vegetables | | | |
| (e.g. cauliflower, brussel sprouts, asparagus) | 0 | 1 | 2 |
| Avoid red fruits or vegetables | | | |
| (e.g. tomatoes, cranberries, cherries) | 0 | 1 | 2 |
| Bad breath | 0 | 1 | 2 |
| Consume commercially produced dairy products | 0 | 1 | 2 |
| Consume hydrogenated fats | 0 | 1 | 2 |
| Craving for alcohol | 0 | 1 | 2 |
| Craving for bread, starches, pasta | 0 | 1 | 2 |
| Craving for coffee / tea / cola | 0 | 1 | 2 |
| Craving for fatty foods | 0 | 1 | 2 |
| Craving for salt | 0 | 1 | 2 |
| Craving for spicy foods | 0 | 1 | 2 |
| Craving for sweets, fruit | 0 | 1 | 2 |
| Craving for vinegar, ketchup | 0 | 1 | 2 |
| Other cravings -- type: | 0 | 1 | 2 |
| Distress eating fatty foods | 0 | 1 | 2 |
| Drink carbonated beverages | 0 | 1 | 2 |
| Drink fluoridated water | 0 | 1 | 2 |
| Eat commercially raised meat | 0 | 1 | 2 |
| Eat cooked and/or processed food | 0 | 1 | 2 |
| Eat rapidly, without chewing thoroughly | 0 | 1 | 2 |
| Eat until you feel full | 0 | 1 | 2 |
| Emotional or stress eater | 0 | 1 | 2 |
| Feel a need to eliminate too soon after eating | 0 | 1 | 2 |
| Feel flush after eating | 0 | 1 | 2 |
| Feel sleepy or have low energy after eating | 0 | 1 | 2 |
| Feel too full after eating | 0 | 1 | 2 |
| Food passes through undigested | 0 | 1 | 2 |
| Foreign travel in the last 90 days | 0 | 1 | 2 |
| Get indigestion after eating | 0 | 1 | 2 |
| Have diarrhea after eating | 0 | 1 | 2 |
| Have difficulty breathing after eating | 0 | 1 | 2 |
| Have uncomfortable or adverse reactions after eating | 0 | 1 | 2 |
| History of food poisoning | 0 | 1 | 2 |
| Low carbohydrate diet | 0 | 1 | 2 |
| Low energy | 0 | 1 | 2 |
| Low fiber diet | 0 | 1 | 2 |
| Undergone surgery in the last 90 days | 0 | 1 | 2 |
| Practice mindful eating (No distractions, e.g., TV or work) | 0 | 1 | 2 |
| Read nutrition labels | 0 | 1 | 2 |

| Item | | | |
|---|---|---|---|
| Age spots | 0 | 1 | 2 |
| Avoid exercise | 0 | 1 | 2 |
| Bulemia (binge / purge) | 0 | 1 | 2 |
| Cholesterol above 200 | 0 | 1 | 2 |
| Difficulty gaining or maintaining weight | 0 | 1 | 2 |
| Difficulty losing weight even on a diet | 0 | 1 | 2 |
| Difficulty strengthening muscles | 0 | 1 | 2 |
| Drink chlorinated water | 0 | 1 | 2 |
| Drink non-filtered water | 0 | 1 | 2 |
| Drink sweet beverages | 0 | 1 | 2 |
| Eat candy or sweets | 0 | 1 | 2 |
| Eat fatty foods | 0 | 1 | 2 |
| Eat food that is not organically grown | 0 | 1 | 2 |
| Eat less than four servings of grain each day | 0 | 1 | 2 |
| Eat less than three servings of fresh fruit each day | 0 | 1 | 2 |
| Eat less than two servings of dairy products each day | 0 | 1 | 2 |
| Eat less than two servings of fresh, dark-colored | | | |
| vegetables each day | 0 | 1 | 2 |
| Eat more than 6 oz of protein per day | 0 | 1 | 2 |
| Eat white bread | 0 | 1 | 2 |
| Excessive fatigue during workouts | 0 | 1 | 2 |
| Eat meat (vegetarian or vegan) | 0 | 1 | 2 |
| Excessive wrinkling of the skin/premature aging | 0 | 1 | 2 |
| Food allergy, proven or suspected | 0 | 1 | 2 |
| Graying of the hair | 0 | 1 | 2 |
| Have a small appetite | 0 | 1 | 2 |
| Have stress in your life | 0 | 1 | 2 |
| High fat diet | 0 | 1 | 2 |
| Hungry soon after meal | 0 | 1 | 2 |
| Hyperactivity or excessive nervousness without food | 0 | 1 | 2 |
| Muscles feel weak after performing daily activities | 0 | 1 | 2 |
| Persistent leg cramps | 0 | 1 | 2 |
| Poor smell / taste | 0 | 1 | 2 |
| Poor stamina or strength | 0 | 1 | 2 |
| Pulse speeds after meals | 0 | 1 | 2 |
| Sleepy after meals | 0 | 1 | 2 |
| Take vitamins | 0 | 1 | 2 |
| Trouble sleeping | 0 | 1 | 2 |
| Unpleasant taste in mouth | 0 | 1 | 2 |
| Weakness or faintness between meals | 0 | 1 | 2 |
| Weight gain | 0 | 1 | 2 |
| Weight loss | 0 | 1 | 2 |
| Would you like to work with our nutritionist ? | Yes | | No |

Physician Comments:______________________________________________

______________________________________________________________

Physician Signature:______________________________________________



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## PATIENT MEDICAL HISTORY

**Patient Name:**_______________________________________________ **Date:** _______________

| Describe your health history<br>Birth: |
|---|
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| First 5 years: |
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| 5-10 years of age: |
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| 11-17 years of age: |
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| 18-25 years of age: |
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| 26-35 years of age: |
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| 36-45 years of age: |
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| 46-55 years of age: |
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| 56 - to current age: |
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