Bayside
Regenerative
Medicine

KRISTIN KALMBACHER, MD, MPH

100 North Bancroft Street - Suite A2
Fairhope, Alabama 36532
Phone: 251-517-1050
Fax: 251-517-1051

# PATIENT REGISTRATION

DATE: _____

Last Name: _____ First Name: _____ MI: ___

SS#: _____ Date of Birth: _____ Marital Status: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

E-mail(s): _____

Employer: _____ Work #: _____

Emergency Contact Name: _____ Phone #: _____

## GUARANTOR INFORMATION (if different from above)

Last Name: _____ First Name: _____ MI: _____

SS#: _____ Date of Birth: _____

Relationship to Patient: Spouse _____ Parent _____ Other: _____

Address (If different from above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

## INSURANCE INFORMATION

Type of Insurance: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth of Policy Holder: _____

Is this visit due to an accident? Yes _____ No _____

If yes, was it: Auto _____ Work _____ Other: _____

Has the accident been reported? Yes _____ No _____ Date of report: _____

Do you have an Attorney? Yes _____ No _____

If yes, give Attorney information:

Name: _____

Address: _____

Phone: _____

Bayside Regenerative Medicine
Kristin Kalmbacher, MD, MPH

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baysideregenerativemedicine.com

# DISCLOSURES AND CONSENTS

(Initials)

## ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize and assign direct payment of my insurance benefits to Bayside Regenerative Medicine, or the physician individually, for services rendered to me or my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pays, deductibles and/or balances due to Bayside Regenerative Medicine.

By signing this document, I acknowledge that I am responsible for the financial obligation arising from services rendered to myself or to my dependents. I acknowledge that I will incur the reasonable cost of collections including attorney's fees should I fail to satisfy my financial obligation.

(Initials)

## AUTHORIZATION FOR TEXTS AND / OR E-MAIL NOTIFICATIONS

I hereby authorize the staff of Bayside Regenerative Medicine to notify me by means of text messaging or e-mail regarding reminders for scheduled appointments. I understand that, in some instances, depending upon my text messaging/e-mail provider contract, I might incur a one-time charge for such services.

(Initials)

## AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I certify that I have received and read a copy of the Bayside Regenerative Medicine Patient Information Privacy Policy. I hereby authorize Bayside Regenerative Medicine or the physician individually to release any of my or my dependents' medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

(Initials)

## AUTHORIZATION TO MAIL, CALL OR E-MAIL

I certify that I understand the provacy risk of mail, phone calls and e-mail. I hereby authorize Bayside Regenerative Medicine's representatives or my physician to mail, phone or e-mail me with communications regarding my healthcare, including appointment reminders, referral arrangements, and/or test results. I understand that I have the right to rescind this authorization at any time by notifying Bayside Regenerative Medicine in writing.

(Initials)

## CONSENT TO TREAT

I hereby consent to evaluation, testing and treatment as directed by the treating physician at Bayside Regenerative Medicine.

(Initials)

## NO SHOW FOR APPOINTMENT

I understand that I will be charged a $50.00 fee for all missed appointments should I fail to notify Bayside Regenerative Medicine within a reasonable amount of time (usually 24 hours).

(Initials)

## RETURNED CHECKS

I understand that there will be a fee of $25.00 for any checks or payments returned to Bayside Regenreative Medicine by my bank or financial institution.

(Initials)

## LABORATORY TEST KITS

I understand that all Laboratory Test Kits purchased from this office must be returned unused within 14 days in order to receive a refund.

PRINTED PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____

# NOTICE OF PRIVACY PRACTICES

**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.***

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

## NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

**Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

**Right to Request Removal from Fundraising Communications.** You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact _KALA BUNCH, Privacy Officer, [251 929-3590 7540 CIPRIANO COURT SUITE B. FAIRHOPE, AL 36532]. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

**I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.**

**Patient or Patient's Personal Representative** _____ **Date** _____

Bayside Regenerative Medicine
Kristin Kalmbacher, MD, MPH

# MEDICAL HISTORY AND SYMPTOMATIC QUESTIONNAIRE

100 North Bancroft Street - Suite A2
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Phone: 251-517-1050 Fax: 251-517-1051
baysideregenerativemedicine.com

PATIENT NAME: _____

## PERSONAL INFORMATION

| | |
|---|---|
| Date completed: | Primary Phone: |
| Ful Name: | Other Phone: |
| Address: | Fax: |
| City: | E-mail(s): |
| State: Zip: | |

Date of Birth: _____

Gender: Male: ◯ Female: ◯ Transgender: ◯

Height: _____

Weight: Current: _____ Ideal: _____

Frame: Small: ◯ Medium: ◯ Large: ◯

Body Type: Masculine: ◯ Feminine: ◯ Androgenous: ◯

## EMERGENCY CONTACT INFORMATION:

| | NAME: | RELATION: | PHONE: |
|---|---|---|---|
| 1) | | | |
| 2) | | | |
| 3) | | | |

## SPECIALISTS SEEN:

| | |
|---|---|
| Name: | Name: |
| Specialty: | Specialty: |
| Address: | Address: |
| Adddress: | Adddress: |
| City: | City: |
| State: Zip: | State: Zip: |
| Office Phone: | Office Phone: |
| Office Fax: | Office Fax: |
| Office E-mail: | Office E-mail: |

MEDICAL HISTORY AND SYMPTOMATIC QUESTIONNAIRE

PATIENT NAME _____

CHIEF GOAL: (Please explain why you came to see the physician)

_____

_____

_____

_____

_____

_____

_____

_____

| ENERGY LEVEL: | Time of Day | Energy Level - 1 (Low) to 10 (High) |
|---|---|---|
| Breakfast | | |
| Mid-Morning | | |
| Lunch | | |
| Mid-Day | | |
| Dinner | | |
| Late Night | | |
| Bedtime | | |

SLEEP PATTERN:

| | |
|---|---|
| Length of time it takes to fall asleep: | |
| Hours slept before waking for the first time: | |
| Average hours slept each night: | |

SLEEP PROBLEMS:

| | | |
|---|---|---|
| Do you snore? | Yes ○ | No ○ |
| Do you wake with a headache? | Yes ○ | No ○ |
| Do you awake feeling tired/not rested? | Yes ○ | No ○ |
| Do you have trouble falling asleep? | Yes ○ | No ○ |
| Do you wake up often throughout the night? | Yes ○ | No ○ |
| Do you have trouble falling back to sleep once awakened? | Yes ○ | No ○ |
| Do you urinate often (more than once) during the night? | Yes ○ | No ○ |
| Do you use a sleep apnea device? | Yes ○ | No ○ |
| Do you to take herbal or over-the-counter medications to sleep? | Yes ○ | No ○ |
| Do you take prescription medications to sleep? | Yes ○ | No ○ |
| Has anyone observed you stop breathing during sleep? | Yes ○ | No ○ |

PATIENT NAME _____

SLEEP PROBLEMS (continued)

| | | |
|---|---|---|
| Do you kick or jerk your legs/arms during your sleep? | Yes ○ | No ○ |
| Do you awaken at night choking, smothering or gasping for air? | Yes ○ | No ○ |
| Do you experience restlessness, tingling or crawling in your arms or legs? | Yes ○ | No ○ |
| Do you experience inability to keep your legs still prior to falling asleep? | Yes ○ | No ○ |
| Do you talk in your sleep as an adult? | Yes ○ | No ○ |
| Have you sleep walked as an adult? | Yes ○ | No ○ |
| Does your heart pound at night? | Yes ○ | No ○ |

PATIENT CANCER HISTORY

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Breast (women / men) | ○ | ○ | |
| Uterine (women) | ○ | ○ | |
| Cervical (women) | ○ | ○ | |
| Prostate (men) | ○ | ○ | |
| Testicular (men) | ○ | ○ | |
| Colon | ○ | ○ | |
| Skin | ○ | ○ | |
| Lung | ○ | ○ | |
| Bladder | ○ | ○ | |
| Kidney | ○ | ○ | |
| Thyroid | ○ | ○ | |
| Pancreatic | ○ | ○ | |
| Lymphoma | ○ | ○ | |
| Leukemia | ○ | ○ | |
| Other (name) _____ | ○ | ○ | |

HEART DISEASE / VASCULAR

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Heart Attack | ○ | ○ | |
| Congestive Heart Failure | ○ | ○ | |
| Blockage of Coronary Artery | ○ | ○ | |
| Angiogram | ○ | ○ | |
| Stent Placement | ○ | ○ | |
| Carotid Artery Stenosis | ○ | ○ | |

PATIENT NAME _____

## NEUROLOGIC PROBLEM

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Stroke | ○ | ○ | |
| Migraines | ○ | ○ | |
| Brain Injury / Concussion | ○ | ○ | |
| Seizures | ○ | ○ | |

## BLOOD PRESSURE

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| High Blood Pressure (hypertension) | ○ | ○ | |
| Low Blood Pressure (hypotension) | ○ | ○ | |

## BLEEDING PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Blood Clots | ○ | ○ | |
| Hemophilia | ○ | ○ | |
| Factor V Leiden | ○ | ○ | |

## CHOLESTEROL PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| High Cholesterol | ○ | ○ | |
| High LDL Cholesterol | ○ | ○ | |
| High HDL Cholesterol | ○ | ○ | |
| High Triglycerides | ○ | ○ | |

## BLOOD SUGAR PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Elevated blood sugar (pre-diabetic) | ○ | ○ | |
| Diabetes (onset in youth, treated with insulin) | ○ | ○ | |
| Diabetes (onset as adult, treated with diet) | ○ | ○ | |
| Diabetes (onset as adult, treated with medication) | ○ | ○ | |

## JOINT PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Arthritis | ○ | ○ | |
| Rheumatoid Arthritis | ○ | ○ | |
| Gout (Arthritis) | ○ | ○ | |

## BONE LOSS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Osteopenia (weakening bones) | ○ | ○ | |
| Osteoporosis (weak bones) | ○ | ○ | |

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MEDICAL HISTORY AND SYM_ _OMATIC QUESTIONNAIRE

PATIENT NAME _____

## MENTAL DISORDERS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Depression | ○ | ○ | |
| Bipolar | ○ | ○ | |
| History of Suicide Attempts | ○ | ○ | |
| Anger Management Problem | ○ | ○ | |
| Post Traumatic Stress Disorder | ○ | ○ | |
| Substance Abuse | ○ | ○ | |

## STOMACH PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Ulcers | ○ | ○ | |
| Reflux (Heartburn) | ○ | ○ | |
| Poor Digestion | ○ | ○ | |
| Diarrhea | ○ | ○ | |
| Constipation | ○ | ○ | |

## THYROID PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Hypothyroidism | ○ | ○ | |
| Hashimoto's Thyroiditis | ○ | ○ | |
| Hyperthyroidism (High Thyroid) | ○ | ○ | |
| Thyroid Nodules | ○ | ○ | |

## LUNG PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Asthma | ○ | ○ | |
| Emphysema (COPD) | ○ | ○ | |
| Pulmonary Hypertension | ○ | ○ | |

## WEIGHT PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Obesity | ○ | ○ | |
| Overweight | ○ | ○ | |
| Anorexia | ○ | ○ | |
| Bulimia | ○ | ○ | |

## ENERGY PROBLEMS

| Type: | Past | Present | How was it treated? |
|---|---|---|---|
| Chronic Fatigue Syndrome | ○ | ○ | |
| Fibromyalgia | ○ | ○ | |

MEDICAL HISTORY AND SYM_ _OMATIC QUESTIONNAIRE

PATIENT NAME _____

## PRESCRIPTION MEDICATION

| Name | Strength | How Many | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## HORMONE THERAPY

| Name | Strength | How Many | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## OVER THE COUNTER MEDICATIONS

| Name | Strength | How Many | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## VITAMINS AND SUPPLEMENTS

| Name | Strength | How Many | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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MEDICAL HISTORY AND SYMPTOMATIC QUESTIONNAIRE

PATIENT NAME _____

## ENVIRONMENTAL ALLERGIES

| | Name | Trouble Breathing | Rash / Hives | Other Reaction |
|---|---|---|---|---|
| Aerosol: | Cologne | | | |
| | Smoke | | | |
| | Cleaning Fluids | | | |
| Seasonal: | Ragweed | | | |
| | Mold | | | |
| | Dust | | | |
| Pet/Animal: | Dog | | | |
| | Cat | | | |
| Latex: | Gloves | | | |
| | Tape | | | |
| Other: | | | | |

## FOOD ALLERGIES

| Name of Food | Trouble Breathing | Rash / Hives | Other Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## SOCIAL HISTORY

| | | | |
|---|---|---|---|
| Occupation | | | |
| Sexual Orientation | Heterosexual (Straight) ○ | Homosexual (Gay) ○ | Bisexual ○ |
| Marital Status | Single ○ | Married/Partnered ○ | Divorced/Widowed ○ |
| Use of Tobacco | Yes ○ | No ○ | Quit ○ |
| Use of Alcohol | Yes ○ | No ○ | In Recovery ○ |
| Use of Caffeine | A Lot ○ | Sometimes ○ | Rarely ○ |
| Location of Home | City ○ | Suburbs ○ | Country ○ |
| Children | | | |

Have you ever been a victim of violence (including physical, psychological, emotional, economic and sexual abuse)? Yes ○ No ○

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MEDICAL HISTORY AND SY... TOMATIC QUESTIONNAIRE

PATIENT NAME _____

## CONTRACEPTIVE HISTORY

| | | |
|---|---|---|
| Birth Control Pills: | Type: | Total Years: |
| | Type: | Total Years: |
| Diaphragm / Cap | Type: | Size: |
| IUD | Type: | Last Change: |
| Norplant, Condom and/or Foam, Suppository: | | |
| Hysterectomy ◯ | Partner with Vasectomy ◯ | None ◯ |
| Other: | | |
| Problem with Current Method: | | |

| EXPOSURE / TOXICOLOGY | Yes | No | Explain |
|---|---|---|---|
| Radiation | | | |
| Second-hand Smoke | | | |
| Asbestos | | | |
| Lead | | | |
| Coal | | | |
| Electronic (Power Lines, Wi-Fi, Cell Phone, etc.) | | | |
| Artificial Sweeteners (Splenda, Equal, etc.) | | | |
| Other: | | | |

| FAMILY HISTORY | Mother | Father | Brother | Sister | Other |
|---|---|---|---|---|---|
| Breast Cancer | | | | | |
| Uterine Cancer | | | | | |
| Prostate Cancer | | | | | |
| Colon Cancer | | | | | |
| Heart Attack | | | | | |
| Heart Disease | | | | | |
| High Cholesterol | | | | | |
| High Blood Pressure | | | | | |
| Diabetes | | | | | |
| Stroke | | | | | |
| Obesity | | | | | |
| Kidney Disease | | | | | |
| Liver Disease | | | | | |
| Lung Disease | | | | | |
| Osteoporosis | | | | | |
| Alzheimers / Dementia | | | | | |
| Mental Disease | | | | | |
| Alcoholism | | | | | |
| Drug Abuse | | | | | |
| Other: | | | | | |
| Other: | | | | | |

PATIENT NAME _____

PREFERRED PHARMACY

PRIORITIZE YOUR MOST IMPORTANT HEALTH CONCERNS

| Concern | Onset | Frequency | Severity |
|---|---|---|---|
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |

What prior experiences have you had with alternative or complementary medicine?

LIFESTYLE

What physical activity do participate in and how often?

NUTRITION

What are your sources of protein? _____

What types of oils or spreads do you add to your food? _____

What and how much do you drink on a typical day? (Water, Caffeine drinks including sodas) _____

How would you describe your relationship with food? _____

How often do you eat out? _____

Who prepares the meals at home? _____

MEDICAL HISTORY AND SYMPTOMATIC QUESTIONNAIRE

PATIENT NAME _____

SOURCES OF STRESS (Rank your stressors from 1 [Low] to 5 [High] - Please circle)

| | | | | | |
|---|---|---|---|---|---|
| Are your children stressful to you? | 1 | 2 | 3 | 4 | 5 |
| Is your spouse / significant other stressful to you? | 1 | 2 | 3 | 4 | 5 |
| Are finances stressful to you? | 1 | 2 | 3 | 4 | 5 |
| Is your job stressful to you? | 1 | 2 | 3 | 4 | 5 |

OTHER SOURCES OF STRESS

| | | | | | |
|---|---|---|---|---|---|
| 1) | 1 | 2 | 3 | 4 | 5 |
| 2) | 1 | 2 | 3 | 4 | 5 |
| 3) | 1 | 2 | 3 | 4 | 5 |
| 4) | 1 | 2 | 3 | 4 | 5 |
| 5) | 1 | 2 | 3 | 4 | 5 |

| STRESS MANAGEMENT | Yes | Sometimes | No |
|---|---|---|---|
| Do you meditate? | | | |
| Do you exercise? | | | |
| Do you get enough sleep? | | | |
| Other: _____ | | | |

STRESS RELIEVERS (List the things that you do to relieve your stress)

| |
|---|
| 1) |
| 2) |
| 3) |
| 4) |
| 5) |

DRUG ALLERGIES (Write "None" if you do not have allergies)

| Name of Drug | Trouble Breathing | Rash / Hives | Other Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PATIENT NAME _____

## EXERCISE HISTORY

| Type of Exercise | Number of Times Per Week | Length of Time Exercising |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## PREVIOUS DIAGNOSTIC TESTING

| Type: | Year | Results |
|---|---|---|
| Mammogram | | |
| Thermogram (Breast) | | |
| Pap Smear (Women) | | |
| Uterine Ultrasound (Women) | | |
| Prostate Exam (Men) | | |
| Colonoscopy | | |
| Skin Exam | | |
| Eye Exam (Glaucoma) | | |
| Bone Density / Scan | | |
| Cardiac Stress Test | | |
| Calcium Coronary Scan | | |
| Carotid Artery Ultrasound | | |
| Other: | | |
| Other: | | |

| FAMILY HISTORY | Age | Alive | Deceased | Cause of Death |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Maternal Grandmother | | | | |
| Maternal Grandfather | | | | |
| Paternal Grandmother | | | | |
| Paternal Grandfather | | | | |

## PAST SURGICAL HISTORY

| Type: | Year | Results |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |
| 6) | | |
| 7) | | |

PATIENT NAME _____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate 0 - 10 with 10 being 100% commited)

0 1 2 3 4 5 6 7 8 9 10

If you answered less than 10, what stands between your current commitment and 100%? _____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? _____

What do you love most about your life at this time? _____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? _____

What are your top three expectations of me as a physician? _____

Specific questions you have for me: _____