Namaste
Natural Healing Center Inc.
A heart centered approach to healing mind, body, and spirit.

Patricia J Meyer, ND Lee Dennis, ND 12616 SE Stark Street Portland, OR 97233 (503) 408-0790

Office Hours: 9:00 – 12:30 and 1:30 – 5:00, Monday – Friday

Preparing for Your Visit: We encourage you to call our office with any questions in order to ensure that you get the most out of your treatment here. If you are a new patient, we will send you new patient paperwork before your first appointment. Please bring your completed paperwork and the bottles of any prescriptions or supplements that you are taking. Please check in 15 minutes before your appointment time. For returning patients, please bring the bottles of any prescriptions or supplements that have changed.

Health Care Team: In order to offer consistent, comprehensive care, Namaste Natural Healing Center, Inc. has adopted the physician-led health care team model. Patients play the most important role in our health care team, and we encourage you to partner with us in order to receive the highest quality care. Beyond the patient, our health care team consists of Dr. Meyer, Dr. Dennis, and our office staff. As a cooperative practice, your choice of doctor will always be honored, or you can see them interchangeably, but please be aware that insurance networks vary for each doctor. The office staff supports your care through handling administrative requests and is responsible for coordination of care if referrals to other offices or specialists are necessary.

Medication Refills: Medications that you obtain through a regular pharmacy list the number of refills remaining on the medication label. For those with refills remaining, you may call the pharmacy directly for refills. If there are no refills remaining, please call the pharmacy and they will fax a request for refills to our office. Please note that you may need to see the doctor before refills are issued, in order to treat you safely and with the best dosage of your medication. Please allow 48 hours for all communication from the pharmacy and our office to be completed. For medications that are made up in our office, please give us 24 hours notice so that we may have them ready for you when you arrive. For off the shelf medicines, stop in for them anytime during our regular business hours.

Contacting our Office: **P**lease contact our office with any questions and we would be happy to assist you. Patients can expect a maximum response time of 24 hours for patient requests, and clinical advice calls will be answered the same day if received during business hours. For urgent patient needs outside of normal business hours, please contact the on-call doctor.

On-call doctor: The on-call doctor is available for our patients who are experiencing an urgent condition (one that is too serious to wait until regular office hours). To reach the on-call doctor, call the office number (503) 408-0790 and the message machine will give you the pager number for the doctor on-call. Please note that the pager numbers change frequently, so you must call the office first. Also, please be aware that if your phone does not accept calls from unlisted numbers, the on-call doctor may not be able to reach you. Please disconnect this feature from your phone before paging the on-call doctor.

For medical/life threatening emergencies: Call 911 or go to the nearest emergency room.

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PATIENT AGREEMENT

APPOINTMENTS

We consider an appointment to be an agreement between you and our office. We are responsible to be here and to provide our services, or inform you otherwise. You are responsible for keeping the appointment or giving us 24 hours notice of cancellation. Missed appointments mean another patient who was in need of our services could not be seen because time was reserved for you. Most of our patients are extremely conscious of this and are very considerate in rescheduling in advance when this becomes necessary. For this we are grateful. For those few who decide not to keep your appointment without giving us the appropriate notice, except in cases of extreme emergency, we want you to be aware that you will be charged for the missed appointment.

PAYMENT

In order for us to keep our services available to you, it is necessary to require payment at the time of your visit. We will accept insurance after obtaining verification of coverage and benefits for naturopathic services. You will be responsible for payment of charges not covered by your insurance. Please be aware that most insurance companies don't cover your medicines, so we ask that these be paid for at the time they are dispensed. If you have financial hardship and need to make arrangements for a payment plan to cover your office visits, please discuss this with the front desk staff before your appointment is scheduled.

RIGHTS

- You have the right to be treated with courtesy, respect, and dignity.
- You have the right to know the process through which services are offered, including the general course of treatment.
- If a medication is prescribed, or any other specific treatment is recommended, you have the right to know what is expected to change, and any side effects which might be anticipated.
- Sometimes we have visiting health care professionals or doctors in training present in our office in order for them to learn about naturopathic medicine. You have the right to refuse that anyone but your doctor observe or participate in your consultation or treatment.
- You have the right to refuse treatment for any service or therapy you do not wish to have performed.

CONFIDENTIALITY

If an outside person or agency requests information concerning a patient, we require that their inquiry be in writing. No information or medical records will be released from our office without prior written consent, in the form of a release of records form, signed by you, the patient, unless you are in emergency care or as required by law. This ensures that what you reveal in confidence to your doctor will not be released to anyone without your knowledge and consent.

ASSIGNMENT OF BENEFITS

I hereby assign my medical benefits payable for services rendered by the doctors at Namaste Natural Healing Center, Inc., and/or Dr. Patricia J. Meyer, and/or Dr. Lee James Dennis. This assignment will remain in effect until it is revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I authorize Namaste Natural Healing Center, Inc. to release all information necessary to secure payment in full. I understand that I am financially responsible for all the charges, whether or not they are paid by an insurance company or attorney.

FOR OUR RECORDS: To indicate that you have read and understand these policies, please sign below. If you have questions, please ask.

SIGNED: _____ **DATE:** _____

PATIENT OR GUARDIAN: _____ **DATE:** _____

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be directly or indirectly involved in that treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Namaste Natural Healing Center, Inc has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any given time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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NEW PATIENT REGISTRATION

PATIENT'S LEGAL NAME: _____ DATE: _____

NAME YOU GO BY: _____ DATE OF BIRTH: _____

SEX: Male Female GENDER YOU IDENTIFY WITH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: ( ) _____ CELL PHONE #: ( ) _____

EMAIL ADDRESS: _____

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE: _____

SPOUSE'S NAME: _____

REFERRED BY: _____

YOUR EMPLOYER: _____ WORK PHONE #: ( ) _____

POSITION: _____ HOURS YOU WORK: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S WORK PHONE #: ( ) _____

PRIMARY INSURANCE CARRIER: _____

ADDRESS FOR CLAIMS: _____

PRIMARY INSURED NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

POLICY #: _____ GROUP #: _____

FAMILY MEMBERS COVERED UNDER THIS POLICY: _____

_____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE #: ( ) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT AND/OR CHARGES NOT COVERED BY MY INSURANCE.

SIGNATURE: _____DATE: _____

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NEW PATIENT INTAKE FORM

NAME: _____ DATE: _____

BIRTH DATE: _____ AGE: _____ SEX: M F

MARITAL STATUS: MARRIED SEPARATED DIVORCED WIDOWED SINGLE PARTNERSHIP

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

WHEN AND WHERE DID YOU RECEIVE YOUR LAST HEALTH CARE? _____

_____

WHAT WAS THE REASON? _____

_____

PLEASE LIST YOUR HEALTH PROBLEMS OR CONCERNS IN ORDER OF IMPORTANCE TO YOU:

1. _____ **4. _____**

2. _____ **5. _____**

3. _____ **6. _____**

PLEASE LIST ALL *ALLERGIES*:

DRUG: _____

FOOD: _____

ENVIRONMENTAL: _____

DO YOU TAKE ALLERGY SHOTS OR HAVE YOU IN THE PAST? _____

PAST MEDICAL HISTORY:

PLEASE LIST ALL *HOSPITALIZATIONS* (INCLUDE DATE, HOSPITAL, AND REASON): _____

_____

_____

_____

PLEASE LIST ALL *SURGERIES* (INCLUDE DATE, HOSPITAL, AND REASON): _____

_____

_____

_____

MEDICATIONS:

PLEASE LIST ALL CURRENT MEDICATIONS, VITAMINS, AND SUPPLEMENTS (INCLUDING DOSAGES): _____

_____

_____

_____

_____

_____

_____

WHEN WAS YOUR LAST *PHYSICAL EXAM*? _____ *LABS*? _____

HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY AND INDICATE DATE)

BIOPSY_____ BONE DENSITY TEST_____ COLONOSCOPY_____ MAMMOGRAM_____

ULTRASOUND_____ MRI_____ EKG_____ FLU VACCINE_____ PNEUMONIA

VACCINE_____ SHINGLES VACCINE_____ OTHER: _____

Y = YES, CURRENTLY HAVE N = NEVER HAD P = HAD IN PAST

IMMUNIZATIONS:

POLIO	**Y**	**N**	**HEPATITIS B**	**Y**	**N**	**RUBELLA**	**Y**	**N**
PERTUSSIS	**Y**	**N**	**MEASLES/MUMPS**	**Y**	**N**	**DIPTHERIA**	**Y**	**N**
TETANUS	**Y**	**N**	**DATE OF LAST TETANUS SHOT: _____**					
OTHER: _____			**ANY BAD REACTIONS TO IMMUNIZATIONS? _____**					

CHILDHOOD ILLNESSES:

DIPTHERIA	**Y**	**N**	**GERMAN MEASLES**	**Y**	**N**	**MEASLES**	**Y**	**N**
SCARLET FEVER	**Y**	**N**	**RHEUMATIC FEVER**	**Y**	**N**	**MUMPS**	**Y**	**N**
MONO	**Y**	**N**	**EAR INFECTIONS**	**Y**	**N**	**STREP**	**Y**	**N**
THRUSH	**Y**	**N**	**DIAPER RASH**	**Y**	**N**	**ECZEMA**	**Y**	**N**

SKIN:

ACNE	**Y**	**N**	**P**	**LUMPS**	**Y**	**N**	**P**
ITCHING	**Y**	**N**	**P**	**MOLES**	**Y**	**N**	**P**
COLOR CHANGES	**Y**	**N**	**P**	**BOILS**	**Y**	**N**	**P**
ECZEMA	**Y**	**N**	**P**	**ULCERS**	**Y**	**N**	**P**
HIVES	**Y**	**N**	**P**	**RASHES**	**Y**	**N**	**P**
SCALING	**Y**	**N**	**P**	**WARTS**	**Y**	**N**	**P**

HEAD:

HAIR LOSS	**Y**	**N**	**P**	**HEAD INJURY**	**Y**	**N**	**P**
HEADACHES	**Y**	**N**	**P**	**SKULL FRACTURE**	**Y**	**N**	**P**
MIGRAINES	**Y**	**N**	**P**				

EYES:

EYE PAIN	**Y**	**N**	**P**	**CATARACTS**	**Y**	**N**	**P**
DOUBLE VISION	**Y**	**N**	**P**	**DRYNESS**	**Y**	**N**	**P**
GLASSES/CONTACTS	**Y**	**N**	**P**	**GLAUCOMA**	**Y**	**N**	**P**
IMPAIRED VISION	**Y**	**N**	**P**	**TEARING**	**Y**	**N**	**P**

EARS:							
DISCHARGE	Y	N	P	EARACHES	Y	N	P
DIZZINESS	Y	N	P	IMPAIRED HEARING	Y	N	P
RINGING	Y	N	P	TRAUMA TO EAR	Y	N	P
NOSE AND SINUSES:							
FREQUENT COLDS	Y	N	P	HAY FEVER	Y	N	P
NOSE BLEEDS	Y	N	P	SINUS PAIN	Y	N	P
STUFFINESS	Y	N	P	RUNNY NOSE	Y	N	P
MOUTH AND THROAT:							
BLEEDING GUMS	Y	N	P	DIFFICULT SWALLOWING	Y	N	P
CAVITIES	Y	N	P	SORE THROATS	Y	N	P
HOARSENESS	Y	N	P	SORE TONGUE	Y	N	P
COLD SORES	Y	N	P	CANKER SORES	Y	N	P
NECK:							
GOITER	Y	N	P	LUMPS	Y	N	P
PAIN/STIFFNESS	Y	N	P	SWOLLEN GLANDS	Y	N	P
TRAUMA TO NECK	Y	N	P	LOW THYROID	Y	N	P
RESPIRATORY:							
ASTHMA	Y	N	P	BRONCHITIS	Y	N	P
COUGH	Y	N	P	EMPHYSEMA	Y	N	P
PLEURISY	Y	N	P	PNEUMONIA	Y	N	P
SHORT OF BREATH	Y	N	P	EXCESS MUCUS	Y	N	P
LYING DOWN	Y	N	P	TUBERCULOSIS	Y	N	P
AT NIGHT	Y	N	P	SPITTING BLOOD	Y	N	P
EXERTION	Y	N	P	WHEEZING	Y	N	P
CARDIOVASCULAR:							
ANGINA	Y	N	P	CHEST PAIN	Y	N	P
DIZZY STANDING	Y	N	P	HIGH BLOOD PRESSURE	Y	N	P
HEART DISEASE	Y	N	P	MURMURS	Y	N	P
IRREGULAR BEATS	Y	N	P	LEG PAIN ON WALKING	Y	N	P
RHEUMATIC FEVER	Y	N	P	SWELLING ANKLES	Y	N	P
HIGH CHOLESTEROL	Y	N	P				
GASTROINTESTINAL							
BELCHING OR GAS	Y	N	P	BLOOD IN STOOL	Y	N	P
CHANGE IN APPETITE	Y	N	P	CHANGE IN THIRST	Y	N	P
GALL BLADDER DISEASE	Y	N	P	HEARTBURN	Y	N	P
HEMORRHOIDS	Y	N	P	JAUNDICE	Y	N	P
LIVER DISEASE	Y	N	P	ULCERS	Y	N	P
VOMITTING BLOOD	Y	N	P	VOMITTING	Y	N	P

BOWEL MOVEMENTS:

HOW OFTEN? _____

IS THIS A CHANGE?	Y	N	
CONSTIPATION?	Y	N	P
DIARRHEA?	Y	N	P

URINARY:

FREQUENT INFECTIONS	Y	N	P	FREQUENCY AT NIGHT	Y	N	P
INCREASED FREQUENCY	Y	N	P	INABILITY TO HOLD	Y	N	P
KIDNEY STONES	Y	N	P	KIDNEY PAIN	Y	N	P
PAIN ON URINATION	Y	N	P	URETHRAL DISCHARGE	Y	N	P

FEMALE REPRODUCTIVE SYSTEM:

AGE MENSES BEGAN: _____				BIRTH CONTROL	Y	N	P
# OF DAYS YOU BLEED: _____				WHAT TYPE: _____			
# OF DAYS BETWEEN PERIODS: _____				# OF PREGNANCIES: _____			
ARE CYCLES REGULAR?	Y	N	P	# OF LIVE BIRTHS: _____			
PAIN WITH PERIODS	Y	N	P	# OF MISCARRIAGES: _____			
EXCESSIVE FLOW	Y	N	P	# OF ABORTIONS: _____			
PMS	Y	N	P	DIFFICULTY CONCEIVING	Y	N	P
VAGINAL DRYNESS	Y	N	P	MENOPAUSAL SYMPTOMS	Y	N	P
PAIN WITH INTERCOURSE	Y	N	P	VENEREAL DISEASE	Y	N	P
DECREASED SEX DRIVE	Y	N	P	ARE YOU SEXUALLY ACTIVE	Y	N	P
				SEXUAL ORIENTATION (PLEASE CIRCLE):			
				HETEROSEXUAL BISEXUAL HOMOSEXUAL			

BREASTS:

DO YOU DO SELF EXAMS	Y	N	P	LUMPS	Y	N	P
PAIN	Y	N	P	NIPPLE DISCHARGE	Y	N	P
MAMMOGRAMS	Y	N	P	BIOPSY	Y	N	P

MALE REPRODUCTIVE SYSTEM:

HERNIAS	Y	N	P	ABNORMAL RECTAL EXAM	Y	N	P
TESTICULAR PAIN	Y	N	P	DO YOU DO SELF EXAMS	Y	N	P
TESTICULAR MASSES	Y	N	P	ARE YOU SEXUALLY ACTIVE?	Y	N	P
DISCHARGE OR SORES	Y	N	P	DECREASED SEX DRIVE	Y	N	P
PROSTATE DISEASE/PAIN	Y	N	P	SEXUAL DIFFICULTIES	Y	N	P
VENEREAL DISEASE	Y	N	P	SEXUAL ORIENTATION (PLEASE CIRCLE):			
HIGH PSA	Y	N	P	HETEROSEXUAL BISEXUAL HOMOSEXUAL			

MUSCULOSKELETAL:

JOINT PAIN/STIFFFNESS	Y	N	P	BROKEN BONES	Y	N	P
SWELLING OF JOINTS	Y	N	P	MUSCLE CRAMPS	Y	N	P
ARTHRITIS	Y	N	P	WEAKNESS	Y	N	P
GOUT	Y	N	P	OSTEOPENIA	Y	N	P

PERIPHERAL VASCULAR:

COLD HANDS/FEET	Y	N	P	VARICOSE VEINS	Y	N	P
DEEP LEG PAINS	Y	N	P	THROMBOPHLEBITIS	Y	N	P
NUMB HANDS/FEET	Y	N	P	RAYNAUD'S	Y	N	P

NEUROLOGICAL:

DIZZINESS/VERTIGO	Y	N	P	NUMBNESS/TINGLING	Y	N	P
FAINTING	Y	N	P	LOSS OF MEMORY	Y	N	P
SEIZURES	Y	N	P	PARALYSIS	Y	N	P
WEAKNESS	Y	N	P	OTHER: _____			

ENDOCRINE/BLOOD

ANEMIA	Y	N	P	EXCESSIVE THIRST	Y	N	P
EASY BRUISING/BLEEDING	Y	N	P	HEAT/COLD INTOLERANCE	Y	N	P
EXCESSIVE HUNGER	Y	N	P	HYPOTHYROID	Y	N	P

CURRENT WEIGHT: _____ WEIGHT 1 YEAR AGO: _____ IDEAL WEIGHT: _____ HEIGHT: _____

MENTAL/EMOTIONAL:

ANXIETY/NERVOUSNESS	Y	N	P	EXCESSIVE FEARS	Y	N	P
DEPRESSION	Y	N	P	MOOD SWINGS	Y	N	P
EXCESSIVE ANGER	Y	N	P	HYPERACTIVITY	Y	N	P
ATTENTION DEFICIT	Y	N	P	EXCESSIVE STRESS	Y	N	P

OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
LITTLE INTEREST OR PLEASURE IN DOING THINGS	0	1	2	3
FEELING DOWN, DEPRESSED, OR HOPELESS	0	1	2	3

INFANTS AND SMALL CHILDREN:

EAT WELL	Y	N	CONSTIPATION	Y	N	LETHARGY	Y	N
SLEEP THROUGH NIGHT	Y	N	COLIC	Y	N	HYPERACTIVITY	Y	N
EAR ACHES	Y	N	DIARRHEA	Y	N	BEHAVIOR ISSUES	Y	N
WEIGHT LOSS/GAIN	Y	N	SKIN RASHES	Y	N	IRRITABILITY	Y	N
DEVELOPMENT DELAY	Y	N	EXCESS FEARS	Y	N	OTHER: _____		

HABITS:

SMOKING Y N P

IF YES, WHEN DID YOU START? _____ IF YOU QUIT, WHEN DID YOU QUIT? _____

HOW MUCH: _____ FREQUENCY: _____

OTHER TYPES OF TOBACCO Y N P TYPE: _____

IF YES, WHEN DID YOU START? _____ IF YOU QUIT, WHEN DID YOU QUIT? _____

HOW MUCH: _____ FREQUENCY: _____

ALCOHOL CONSUMPTION Y N P

HOW MUCH: _____ FREQUENCY: _____

RECREATIONAL DRUGS Y N P

TREATMENT FOR DRUG DEPENDENCE/ALCOHOL ABUSE Y N P TYPE: _____

OF HOURS YOU SLEEP: _____ DO YOU WAKE RESTED? Y N P

EXERCISE HABITS AND FREQUENCY: _____

YOUR MAIN HOBBIES AND INTERESTS: _____

DO YOU HAVE A RELIGIOUS/SPIRITUAL PRACTICE? Y N P

ARE YOU SEEING A COUNSELOR? Y N P

DO YOU SEE A CHIROPRACTOR? Y N P

ARE YOU RECEIVING ACUPUNCTURE TREATMENTS? Y N P

WHAT ARE YOU DOING TO SUPPORT YOUR HEALING AND GROWTH? _____

_____

IS THERE ANYTHING ELSE YOU THINK I NEED TO KNOW TO HELP YOU WITH YOUR HEALING PROCESS? _____

_____

_____

PATIENT NAME: _____ **DATE:** _____

FAMILY HISTORY – PLEASE CHECK ALL THAT APPLY

FATHER:

- ☐ LIVING AGE: _____
- ☐ DECEASED AGE:_____
  CAUSE: _____
- ☐ HISTORY UNKOWN
- ☐ OTHER: _____

- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE:_____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE

- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

MOTHER:

- ☐ LIVING AGE: _____
- ☐ DECEASED AGE: _____
  CAUSE: _____
- ☐ HISTORY UNKOWN
- ☐ OTHER: _____

- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE: _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE

- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

PATERNAL GRANDFATHER:

- ☐ LIVING AGE: _____
- ☐ DECEASED AGE: _____
  CAUSE: _____
- ☐ HISTORY UNKOWN
- ☐ OTHER: _____

- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE: _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE

- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

PATERNAL GRANDMOTHER:

- ☐ LIVING AGE:_____
- ☐ DECEASED AGE: _____
  CAUSE: _____
- ☐ HISTORY UNKOWN
- ☐ OTHER: _____

- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE: _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE

- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

MATERNAL GRANDFATHER:

- ☐ LIVING AGE: _____
- ☐ DECEASED AGE: _____
  CAUSE: _____
- ☐ HISTORY UNKOWN
- ☐ OTHER: _____

- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE: _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE

- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

MATERNAL GRANDMOTHER:

- ☐ LIVING AGE: _____
- ☐ DECEASED AGE: _____
  CAUSE: _____
- ☐ HISTORY UNKOWN
- ☐ OTHER: _____

- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE: _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE

- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

BROTHER(S):

- ☐ LIVING AGE: _____
- ☐ DECEASED AGE: _____
  CAUSE: _____
- ☐ HISTORY UNKOWN
- ☐ OTHER: _____

- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE: _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE

- ☐ HIGH BLOOD PRESSURE
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL ILLNESS
- ☐ THYROID PROBLEMS

SISTER(S):

- ☐ LIVING AGE:_____
- ☐ DECEASED AGE:_____
  CAUSE: _____
- ☐ HISTORY UNKOWN
- ☐ OTHER: _____

- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER TYPE: _____
- ☐ DIABETES
- ☐ HEART DISEASE/STROKE

- ☐ HIGH BLOOD PRESSURE
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PROVIDER LIST

PATIENT NAME: _____ DATE: _____

DO YOU HAVE A PRIMARY CARE PROVIDER? Y N IF YES, PLEASE LIST THEM FIRST

PLEASE LIST ALL PROVIDERS YOU SEE (INCLUDING MD, DO, PA, NP, LMT, ETC.)

NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: ( ) _____ DATE LAST SEEN: _____

NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: ( ) _____ DATE LAST SEEN: _____

NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: ( ) _____ DATE LAST SEEN: _____

NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: ( ) _____ DATE LAST SEEN: _____

PLEASE USE THE BACK OF THIS FORM IF YOU NEED MORE ROOM