

3471 Regional Parkway
Santa Rosa, California 95403
Office (707) 575-5180
Fax (707) 575-5509

Gordon Medical Associates
Innovative Health Care

Eric Gordon, MD
Wayne Anderson, ND
Neil Nathan, MD
Justin Cauntay, DO
Jane Kennedy, NP, MPH
Mara Williams, NP
Sunjya Schweig, MD
Alan McDaniel, MD
Elizabeth Large, ND
Annemieke Austin, MD

info@gordonmedical.com
www.gordonmedical.com

Appointment Day: _____ Date: _____ Time: _____

Your appointment is with:

- Neil Nathan, MD
- Mara Williams, NP
- Elizabeth Large, ND

- Eric Gordon, MD
- Justin Cauntay, DO
- Sunjya Schweig, MD
- Annemieke Austin, MD

- Wayne Anderson, ND
- Jane Kennedy, NP, MPH
- Alan McDaniel, MD

Dear Patient,

Thank you for scheduling an appointment with Gordon Medical Associates (GMA), an innovative comprehensive health care clinic. We offer our patients everything from alternative to conventional medicine for chronic illness and pain, as well as optimal well-being.

Your treatment may include nutritional advice, osteopathy, natural hormones, detoxification, prolotherapy, cancer supportive care, chelation, and intravenous vitamins and minerals.

We stay informed of the most recent developments in diagnosing and treating illness. We do our best to find the cause of your physical problems and the most efficient and effective treatment.

Our relationships with our patients are based upon integrity, kindness, respect, honoring of personal choices, and the belief that everyone deserves to be supported in reaching their full health potential. It is our intent to offer you hope, along with the better quality of life that comes with improved physical health.

Enclosed are the forms you will need to fill out before your first visit. **Please give yourself time to fill them out thoroughly and bring them in with you.**

Your appointment is scheduled for _____, at _____. Since there will be a lot of information to absorb, we highly recommend bringing a partner or close friend to sit in on your visit with the doctor. We ask you to take an active role in regaining your health, so we suggest that you take notes during your appointment. It would also be helpful to create a list of your questions and bring it with you to your appointment. Your session with the doctor can be recorded for you, at your request.

Due to extreme environmental sensitivity of some of our patients, we ask that you please do not wear any perfume, cologne, or any other strongly scented lotions or products.

If you need any further information before this appointment, please call during our clinic phone hours, Monday – Friday, 9 – 5.

Thank you for your confidence and your time. We look forward to working with you. Please remember to arrive 15 minutes early for your appointment! Thank You!

The Doctors and Staff at Gordon Medical Associates

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Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____

Cell phone _____ Fax phone _____

Email address _____

Date of Birth _____ Sex Female Male

Social Security Number: _____

Employer _____ Occupation _____

Who referred you to our office? _____

Primary Care Physician _____ Phone _____

Emergency Contact _____ Relationship _____

Daytime Phone _____ Eve phone _____

In the interest of keeping our office visit fees as low as possible, and due to staff time involved in patient care, we must charge a fee for some services such as telephone consults, supplement orders, missed visits, reports, etc. To help you get what you need in a timely manner we ask that you give us your credit card number to keep on file for use in such cases. We will keep the number confidential, as we do all of our patient information, and **we will not charge your card without notifying you.**

I understand my credit card number will be encrypted for safety.

I hereby authorize Gordon Medical Associates to keep my signature on file and to charge my credit card for services rendered to me.

Credit Card # _____ Expiration Date _____ Security Code _____

Name on Card _____ (Please print clearly)

Authorized Signature _____ Date _____

Billing address (if different from above) _____

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Payment Policy

Payment of Fees: All fees are due in full at the time of service. Many of the services you may receive from GMA will not be eligible for reimbursement from your insurance company. On your first visit you will receive further information about our clinic, which will include the types of services generally not covered by insurance, as well as other information helpful to you as a patient.

We accept Master Card, Visa, ATM cards, personal checks and cash.

Cancellations and Rescheduling: For first-time appointments, there will be no charge for rescheduling or cancellation requests made at least 72 hours before the time of appointment. For follow-up appointments, we ask for 48 hours' notice. If we don't receive adequate notice, you will be charged for the full fee of the appointment, unless we are able to fill your appointment time with another patient. Appointments for IVs not canceled at least 24 hours in advance will be charged for the full price of the scheduled IV. **Any** changes (cancellations or rescheduling) for appointments scheduled for a Monday or Tuesday must be requested by noon on the previous Friday in order to avoid being charged.

Insurance: Gordon Medical Associates are not participating providers of any insurance company. We opted out of Medicare on October 1, 2005. You may not bill Medicare for services in this office, and insurance secondary to Medicare may or may not pay for services rejected by Medicare. We do not bill insurance directly. If you have health insurance we will be happy to provide you with a *Superbill* to send to your insurance company for reimbursement.

In all cases we need you to provide the information below so that we may send it to labs on your behalf. Some lab fees may be covered by insurance.

Your Name _____

Primary Insurance Company Name _____
(If your primary carrier is Medicare, please provide your secondary insurance information as well.)

Insurance ID Number _____

Insurance Group Number _____

Policyholder Name _____

PLEASE PRESENT YOUR INSURANCE CARD(S) FOR US TO COPY

Payment Agreement

By signing below, I acknowledge that I have read the above *Treatment and Payment Policy*.
I understand and agree to my responsibilities.

Print Name: _____ Date: _____

Signature: _____

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Informed Consent Form of Gordon Medical Associates

A. Many of the treatments offered at Gordon Medical Associates are considered to be alternative or complementary arts as compared to those considered allopathic or conventional. We use an innovative and integral approach to the myriad of complex factors causing chronic disease. We view an individual's disease process as an imbalance in the complex interrelated components of all systems of the human body. There are many factors involved in the bio-regulatory system including genetic predisposition and vulnerability, physical, environmental, toxic or traumatic factors, psycho-emotional stress and trauma, malnutrition, and spiritual disharmony.

The therapeutic protocols we offer, especially treatments involving the administration of nutritional supplementation, herbal or homeopathic medicinal products, while derived from extensive scientific data implying hypothetical applications to the treatment of specific disease, in large part must be considered investigational and/or experimental. We use therapies that are supported by extensive observation and anecdotal data collated by many physicians and investigators. These therapies have not been proven by double-blind placebo controlled studies.

These therapies are, by nature, relatively non-toxic when administered and complied with properly. However, as with medications, there is always a risk of an untoward, unpredictable reaction or adverse side effects.

B. In compliance with Business & Professions Code 2234.1 (a) (1) these alternative and/or complementary services may only be provided after

- 1) informed consent, and
- 2) a good-faith prior examination of the patient, and
- 3) medical indication exists for the treatment or advice, or it is provided for health or well-being.

C. B & P Code 2234.1 (a) (3) states that the alternative and/or complementary treatments "not cause a delay in, or discourage traditional diagnosis of, a condition of the patient."

By signing this form I acknowledge I have been apprised of B & P Code 2234.1 (a) (3). After being duly informed by my physician of my condition, the conventional allopathic treatments and common outcomes, including common adverse events, and the alternative and/or complementary treatments

and common outcomes, including common adverse events, I have exercised my freedom of choice and requested alternative and/or complementary treatments. It is my choice to combine this treatment with conventional treatment or forgo conventional/allopathic treatment. My physician has respected my ability to make my own decisions and has not discouraged me from seeking conventional/allopathic treatment.

D. The nature of the services to be provided are an evaluation and treatment your complaints based on an extensive history and a directed or general physical examination. Treatments are based on the concept of biochemical individuality. Your response to the external and internal environments is generally similar to other human beings. However, many of us because of our genetic uniqueness and our individual life experiences react differently to a given stimulus. Conventional medicine has developed its expertise in dealing with severe physical trauma and life-threatening diseases. It is very effective in some of these areas. When the body or psyche is severely stressed, the general patterns of reaction are similar for most people. When the physical or psychic trauma is less overwhelming or chronic, our individual responses become more pronounced.

I, the client, have been given my own copies of this form and any other written materials, and/or audiotapes, pertinent to my case.

Patient Signature: _____ Date: _____

Printed Name: _____

Eric Gordon, MD, CA License # G82342

Wayne Anderson, ND, PA, CA License # PA 1839

Neil Nathan, MD, CA License # G23996

Justin Cauntay, DO, CA license # 20A9470

Jane Kennedy, NP, CA license # 304333

Mara Williams, ANP, CA License # 345522

Sunjya Schweig, MD, CA License # A93413

Alan McDaniel, MD, CA License # CAG88936

Elizabeth Large, ND, CA License # ND92

Annemieke Austin, MD, CA Licence # A110627

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Notice of Privacy Practices

This notice describes how health information about you may be used and how you can get access to your health information. This is required by the Privacy Regulations stated in Health Insurance Portability and Accountability act of 1996 (HIPPA)

Use and disclosure of health information:

1. To public health authorities that are authorized by law to collect information.
2. Lawsuits and other proceedings in response to a court or administrative order.
3. Required to do so by law enforcement officials.
4. When necessary to reduce or prevent a serious threat to your health and safety or others.
5. If you are a member of U.S. foreign military forces, veterans, and if required by appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. For Workers' Compensation and similar programs.

Your rights regarding health information:

1. **Communications:** You can request that your doctor and/or the medical staff at Gordon Medical Associates communicate with you about your health in a particular manner or at a certain location. You may want us to contact you at your home only.
2. You can request a restriction in our use or disclosure of your health information. You have the right to request that we restrict our disclosure to only certain individuals, such as family members. We are not required to agree; however if we do, we are bound by our own agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information such as medical records, billing records, but not psychotherapy notes. You must submit your request in writing, or complete records request forms available in this office.

4. You may amend your health information if you believe it is incorrect or incomplete. To request copies or an amendment to your health information please complete the required form in our office or request in writing and send to: Gordon Medical Associates 3471 Regional Parkway, Santa Rosa, California 95403.
5. Right to copy of this notice: You are entitled to receive a copy of Notice of Privacy Practice. You may ask us for a copy at any time. Contact our front office or call us at (707) 575-5180.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice in writing or with the secretary of the Dept. of Health and Human Services.
7. Our Practice will obtain your written authorization for uses/disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice, or our health information privacy policies, please contact our office at: (707) 575-5180.

I hereby acknowledge that I have read and reviewed this privacy notice.

Signature: _____ **Date:** _____

Print Name: _____

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SERVICES NOT COVERED BY INSURANCE

We expect that your insurance company will not pay for the items or services that are described below. Insurance companies will only pay for mainstream medical treatments. We offer innovative treatments that are not yet accepted by the medical establishment. Insurance companies do not pay for services they consider to be experimental. Please do not expect them to pay for all of the treatment you receive in our office. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Insurance companies will only pay for services they deem "medically necessary" for your condition. We do not know what your individual policy will cover. **Due to the staff time involved, we do charge the patient for any reports sent to the patient's private insurance company. We do not provide documentation of IV nutritional products to insurance companies.**

At present it is our experience that insurance will not pay for the items or services listed below:

Any part (or all) of an office visit that concerns preventative health maintenance or advice on using non-prescription supplements. (up to \$175 per one half hour visit)

Chelation and intravenous vitamins and mineral treatments. (\$80-\$250+ each)

Trigger point injections that exceed "allowable" guidelines. (generally 8 per year)

Telephone consultations. (\$95 per 15 minutes or less)

Intramuscular injections, with few exceptions. (\$15 - \$50 plus cost of medications)

Administrative fees for staff time, which include insurance prior authorizations, blood handling, lab kits, etc. (see office hand-out, "Information for Patients," which spells out these fees)

You are responsible for payment of *all* fees at the time of service. Only the cost of some injectable medications will be billable to insurance. **Regarding lab work done in our office, we charge a \$50 blood handling fee that is *not* billable to insurance.**

PATIENT UNDERSTANDING AND AUTHORIZATION

I understand that my insurance company will likely not pay for *all* of the services I receive in your office, particularly the services listed in the box above. I agree to be personally and fully responsible for payment of such fees. I understand that, if I choose to appeal to my insurance company for any services that they denied, I may not depend on any further documentation from your office. In any instance that GMA *may* agree to writing a report to "justify" the charges, there will be a charge to me for that report.

I understand that as part of my treatment in this clinic, I may or may not receive any or all of the treatments and services listed herein.

Date

Signature of patient or person acting on patient's behalf

Note: Your health information will be kept confidential. If a claim is submitted to your insurance company, your health information may be shared with that company.

Directions to our office:

Heading south on Hwy #101, take the Airport Blvd exit west (to the right) toward the airport. Go straight through the stoplight and cross the railroad tracks. Turn left immediately after tracks onto Regional Parkway and continue for .3 miles to 3471, which is on the right side just past the FedEx building.

Heading north on Hwy #101, go all the way through Santa Rosa (almost to Windsor – past River Rd and Fulton exits). Go west (to the right) on Airport Blvd toward the airport. Go straight through the stoplight and cross the railroad tracks. Turn left immediately after tracks onto Regional Parkway and continue for .3 miles to 3471, which is on the right side just past the FedEx building.

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Taking the time to fill out this form thoroughly will save you time and money in our office, and help us to help you. Your legible writing or printing in ink is appreciated. Thank you.

HEALTH HISTORY

Patient Name _____ Today's Date _____

For your first appointment:

Please *bring* in any pertinent lab test results and medical records you have.

Before your first appointment: Take your temperature 3 times per day for 3 days. Use a mercury thermometer (if you have one) under your tongue for 5 minutes. Do not eat or drink anything for at least 15 minutes before taking your temperature.

Your first temperature should be approximately 3 hours after you awake; the second and third readings are to be done at 5 to 6 hour intervals. If your temperature is 98.6 degrees for all three readings on day one you do not need to continue this for day 2 and 3. You will need to write these numbers down and bring them in with you to your first appointment.

	First reading of the day	Second reading	Third reading
Day 1	_____	_____	_____
Day 2	_____	_____	_____
Day 3	_____	_____	_____

Are you allergic to any medications? If so please list: _____

What time do you go to bed? _____ What time do you fall asleep? _____

How often do you wake up during the night? _____ How long till you fall back to sleep? _____

Are you stiff when you wake up in the AM? _____

What time do you get out of bed in the AM? _____

Do you feel refreshed after awakening? _____

What do you use (if anything) that brings your energy back? _____

How is your energy? _____
Does it drop in the afternoon? _____ evening? _____ Does it seem to increase at night? _____
How would you characterize your predominant mood(s)? _____

Do you have a spiritual path? _____
How would you characterize your diet? _____

Do you have problems with thinking clearly? _____

Do you note any problems with your memory? _____

Do you have episodes of blurry vision? _____ Visual perception changes? _____

Decrease in peripheral vision? _____ Difficulty seeing at night? _____

Do you experience ringing in the ears (tinnitus)? _____

Do you have problems with balance? _____ Do you often bump into things? _____

Are you more clumsy now than in the past? _____ Do you drop things often? _____

Do you experience any areas of muscle twitching? _____

Do you experience sensations of numbness or tingling? _____

Do you experience cramping in your toes or fingers? _____

Do you have any joint or muscle pains? _____

Are you sensitive to noise or light? _____ Are you sensitive to pressure on your skin? _____

Do you bruise easily? _____

Do you ever have severe headaches? _____

Are you sensitive to static electricity? _____

Do you have headaches without any other illness? _____

If yes to either above please answer the following: Draw in where the headache starts and where it goes.

Right

Left

How often do you have a headache? _____ What precipitates the headache? _____

What do you do to relieve the pain? _____

What have you tried for the pain that didn't work? Please include any "side effects" you experienced.

Do you have a stuffy nose? _____ Have you ever had sinusitis? _____

Do you have nasal allergies? _____

If you have any of the above please list what you have used for relief, if it worked, and any side effects experienced. _____

Do you get frequent sore throats? _____ What causes them? _____

Do your gums bleed with flossing or tooth brushing? _____

Do you have any root canals? _____ How many? _____

Do you have any amalgam (silver) fillings? _____

Have you had amalgam fillings removed? _____ How many? _____ When? _____

Did you have any health problems related to the amalgam removal? _____

Do you have persistent or recurrent swollen glands? _____

Do you have a daily cough? _____ Have you ever had bronchitis or asthma? _____

Have you ever had pneumonia? _____

Do you get short of breath walking up a flight of stairs? _____

Can you carry on a conversation while walking uphill? _____

Have you ever been to a pulmonologist (lung specialist)? _____ If yes, please list the reason and include any medications you took even if you are no longer on them. _____

Do you walk, bike, run, or swim, regularly? _____

Do you do any regular exercise? _____

Do you have a physically demanding job? _____

Do you have high or low blood pressure? _____

Do you experience rapid heart rates or palpitations? _____

Do you have chest pains that come on with exertion and get better with rest? _____

Have you ever seen a cardiologist? _____

If yes, please list the reason, and include any medications you took, even if you are no longer on them.

Has much has your weight fluctuated since you were twenty years old?

_____ 5-15lbs _____ 15-25lbs _____ 25-50lbs _____ greater than 50lbs.

Do you enjoy eating? _____

Do you get full easily? _____

Do you get heartburn or indigestion? _____ How often? _____

Does it occur _____ after meals &/or _____ during the night.

Do you have abdominal bloating and gas? _____ How often? _____ Does it occur soon after meals? _____ One or two hours later? _____ Is it painful? _____

Do you belch frequently? _____

Do you pass gas often enough to be embarrassing to you, or annoying to your partner? _____

Do you have abdominal cramping? _____

Do you have any particular area in your abdomen that hurts or burns on a regular basis? _____

Where and when? _____

How many formed stools do you have per day? _____

If you move your bowels less than once per day please write in the frequency. _____

If you have loose stools write in their frequency. _____

Do your stools tend to be small and hard? _____

Do you have pain with bowel movements? _____

Do you have blood or mucous in your bowel movements? _____

Have you had a sigmoidoscopy or colonoscopy? _____

When was your last rectal exam? _____ Have you ever seen a gastroenterologist? _____

If yes, please list the reason and include any medications you took even if you are no longer on them.

Is your libido different now than ten years ago? _____

Do you have chronic thirst unrelieved by drinking water? _____

How often do you get up to urinate at night? _____

How often do you urinate throughout the day? _____

Has this changed in the last 10 years? _____

Have you had urinary tract infections or kidney infections? _____

Do you have problems with urinary incontinence? _____

Do you have any problems with bowel incontinence? _____

Have you seen a urologist? _____ If yes, please list the reason and include any medications you took even if you are no longer on them. _____

For Men

Is there a family history of prostate hypertrophy or prostate cancer? _____

Have you had a PSA done? _____ If so what is it? _____

Have your erections changed in the last ten years? _____

For Women

Do you experience bladder irritability? _____ Uterine irritability? _____

Is there a family or personal history of breast cancer? _____ Who and age at diagnosis? _____

Is there a family or personal history of uterine cancer? _____ Who and age at diagnosis.? _____

Is there a family or personal history of ovarian cancer? _____ Who and age at diagnosis? _____

Is there a family or personal history of cervical cancer or abnormal paps? _____ Who and age at diagnosis? _____

When was your last pap smear and/or pelvic exam? _____

Have you had a mammogram or thermogram? _____ When? _____

How many pregnancies have you had? _____ miscarriages? _____ abortions? _____
tubal pregnancies? _____

How old were you when your periods began? _____ When they stopped? _____

How many days do/did your periods typically last? _____

Are your cycles regular _____ or irregular? _____

Did you have any of the following PMS or menopausal symptoms:

Bloating or fluid retention _____ Irritability or cry easily _____ Depression _____

Were cramps, nausea, or diarrhea a problem during your period? _____

History of birth control use? _____ When & for how long? _____

History of STDs? _____ Which ones? _____

Please list any hospitalizations below:

Patient Name _____

Date _____

Please mark the severity and frequency of symptoms that you have had in the last 4 weeks.

Symptoms	Current Severity				Current Frequency			
	None	Mild	Moderate	Severe	Never	Occasional	Often	Constant
Tick Bite								
Spotted Rash								
Bull's Eye (EM) Rash								
Linear Red Streaks								
Swollen Glands								
Sore Throat								
Fevers								
Bottom of Feet Hurt, esp in morning								
Joint Pain								
Fingers / Toes								
Ankles / Wrists								
Knees / Elbows								
Hips / Shoulders								
Joint Swelling								
Fingers / Toes								
Ankles / Wrists								
Knees / Elbows								
Hips / Shoulders								
Muscle Pain or Cramps								
Unexplained Back Pain								
Stiffness of Joints, Back								
Muscle Twitching								
Muscle Weakness								
Tremor								
Confusion, Difficulty Thinking								
Problems with Concentration, Reading, Absorbing New Information								
Forget Words, Names, Use Wrong Word								
Forgetfulness, Poor Short Term Memory								
Disorientation, Get Lost								
Mood Swings, Depression, Irritability								
Anxiety, Panic Attacks								
Hallucinations, Delusions, Paranoia, Bi-Polar								
Seizures								
Vertigo, Dizziness								
Off Balance, Tippy								
Headache								



Gordon Medical Associates
Female Hormone Assessment Patient Information Sheet

Patient's Name _____ Date _____

Please answer all questions below

Have you had a hysterectomy? Yes _____ No _____ Date _____ When was your last period? _____

Have you been on hormone replacement therapy? Yes _____ No _____ If yes, what did you take? _____

What other medications are you taking? _____

Do you have any history of fibroid tumor? Yes _____ No _____ Endometriosis? Yes _____ No _____

Do you any history of fibrocystic breast? Yes _____ No _____ Breast cancer? Yes _____ No _____

Do you have any history of fibromyalgia? Yes _____ No _____ Depression? Yes _____ No _____

What types of food do you eat for : Breakfast _____ Lunch _____

Dinner _____ Snack _____

How many glasses do you drink daily? Coffee _____ tea _____ coke _____ wine _____ water _____

What vitamin supplements are you taking? _____

Are you a smoker? Yes _____ No _____ if yes, how many? _____ how long? _____

How many days do you exercise a week? _____ What do you do? _____

Is there a family history of any diseases below?

Uterine Cancer _____ Who _____ Ovarian Cancer _____ Who _____

Breast Cancer _____ Who _____ Heart disease _____ Who _____

Osteoporosis _____ Who _____ Alzheimer's _____ Who _____

Diabetes _____ Who _____ Thyroid disease _____ Who _____

Have you experienced any of the following symptoms recently?

Symptoms	Yes	No	Symptoms	Yes	No
Sleep Disturbance			Decreased sex drive		
Fatigue			Breast tenderness		
Weight Gain			Heavy periods		
Hot flushes / sweat			Headache		
Irritability			Mood Swing		
Anxiety			Hair loss		
Depression			Joint pain		
Memory Loss			Loss of interest		
Mental Fog			Vaginal dryness		
Dry Skin			Painful intercourse		
Bladder Symptoms			Hard to reach climax		

Last pap smear date _____ Results _____ Last mammogram/thermography date _____ Results _____

Do you have any questions for me or comments you would like to share? _____