

Preventive Medicine, Computerized Testing, Traditional Chinese Medicine and Orthopedics

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PLEASE PRINT AND USE BLACK INK ONLY

Date _____

Name Last Name, _____ First name _____ Middle initial _____

(Prefix and/or Suffix--Mr.Ms Dr.,Junior, II, III, etc.) _____

Address _____ City/State/Zip _____

Birth date / / _____ Age _____ M F

Phones: Hm _____ Wk _____ Cell _____

Fax _____ Email _____

SS# - - _____ Insurance Co and Claim Number(s) _____

_____ Medicare Yes No

Emergency Contact Person (name, address, all phones) _____

Employer name,address,phone _____

Person Who Referred You _____

Please circle all categories below that apply to you:

Civil Status: Single Married Separated Divorced Widowed Committed Relationship

Work: Outside home In home Retired **Job type, title:**

Education: High School College Grad School Professional School. **Military Service** Y N

Travel history: (include any illness associated with travel)

Main Health Concern: _____

Health Rating (Rate your health 1-10, 1 poorest, 10 excellent) **General Health** _____ **Quality of Life** _____

Illness Rating (0 is best 10 is worst) **Pain** _____ **Symptoms** _____ **Negative Effect on Work/School** _____

Negative Effect on Family _____ **Medication Use** _____ **Medical Expense** _____

Previous Health Consults/Visits (estimate, circle one) 1-10, 10-20, more than 20

History of Present Health Concern (when did it start, symptoms, how often, how long, kinds of care or testing you have had so far. You may add your own pages for this, or for any item on these pages)

Previous Medical Concerns; and Tests and Treatments You Have Received for Them (include birth history if filling this out for a young child, and note any problems with the birth.)

Hospitalization History

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

You may use the back of the page for more history, or add pages of your own.

Acute illnesses—what types, how often in last five years (colds, flu, stomach problems, sinus infections, etc.)

Current medications (include aspirin and birth control)

Past medications

Vitamins, supplements and herbs

Allergies (drugs, airborne allergies, foods, chemicals, etc.) any hospitalizations, ER visits, desensitization shots, and other treatment you have received for them

Describe work environment: hours; exposure to noise, temperature, chemicals, stress, other

Describe home environment: Size, type, recent rehab? indoor air quality, dust, mold, stress, other
Please include use of cosmetics, soaps, fabric softeners, cleaning supplies, pest sprays, lawn pesticides,
and any other household or garden items with chemicals in them

Describe Diet, Exercise, Recreation

Additional information:

Childhood Illnesses (circle or underline) Scarlet Fever, Rheumatic Fever, Mumps, Measles, Rubella, Polio,
Diphtheria, Tetanus, Chicken Pox

Adult Vaccinations (circle or underline) Tetanus Diphtheria Pertussis (whooping cough) Measles, Mumps,
Rubella Oral polio HIB Hep B Flu shot Pneumovax Other

Acute Problems (circle or underline any you tend to have, or have now) Anxiety, Panic, Bleeding, Chest pain, Dental problems, Digestive problems, Constipation, Diarrhea, Dizziness, Fainting, Fevers, Frequent falling, Infections, Constant headache, Heartbeat irregularities, Lumps or tumors, Sharp or shooting pains, Shortness of breath, Sores that won't heal.

Women Only (circle) Pregnant now y / n Trying to get pregnant y / n Planning a pregnancy y / n

Periods: Age started_____ Length of Periods_____ Date of menopause _____HRT y / n

Post menopausal bleeding or spotting y / n

Birth control method_____ Number of live births _____ Still births_____

Abortions_____ Miscarriages_____ Last delivery_____ Any complications y / n

Sexually active y / n history of multiple partners y / n same-sex partner y / n Able to enjoy sex y / n

Pain during sex y / n or after sex y / n

Any of the following? (circle or underline) Vaginal infections Yeast infections Bladder infections Genital

herpes Genital burning Chlamydia Other STDs Pelvic inflammatory disease Periods: Missed

Irregular Spotting between Heavy bleeding Pain or cramps PMS Ovarian cysts Infertility Breast:

Lumps Pain Fibrocystic disease Cancer

Men Only (circle or underline) Testicles: pain, swelling, changes in size, lumps) Penis: discharge from penis

sores, rash Erection: normal off and on, never Ejaculation: premature, painful, never; Urine:

burning painful leakage hard to urinate blood in urine split or interrupted urinary stream

Prostate: swelling infection cancer STDs Genital herpes Chlamydia Other STDs

Are you sexually active y / n Able to enjoy sex y / n Birth control method:

History of multiple partners History of same-sex partners Other

Family History (circle or underline if any family member has had any of these) AIDS Alcoholism Allergies

Anemia Anxiety Arthritis Asthma Bleeding Bowel Problems Bronchitis Cancer Chronic fatigue

Depression Diabetes Epilepsy Gallbladder Glaucoma Gout Headache Heart Attack Heart Failure

Heart Murmur Heart Other Hepatitis

Immune disease Infections Kidney disease Kidney Stones Lactose intolerance Liver disease Lung

disease Lupus Mental illness Menopause problems Migraines Nervousness Osteoporosis

Pneumonia Prostate disease Rashes Seizures Sexual problems Sexually transmitted disease

Sinus Trouble Stomach problems Stroke Thyroid disease Stroke Tuberculosis Ulcer Other

For each of the problems on the following pages: circle if you have the problem, give an approximate date for the first symptoms, Rate how bad it is, 1-10 with 10 being the worst, and give an estimate if we ask for it, of the number of medications, and the number of herbs and supplements you are taking for it.

Allergy, Food Age Rating #ofMeds #ofHerbs/Suppl FamHist y / n
Previous Skin testing y / n Previous Blood testing y/n

Allergy,FoodAdditive Age Rating #ofMeds #ofHerbs/Suppl

Allergy, Inhalant Age Rating #ofMeds #ofHerbs/Suppl FamHist y / n

(Circle all that apply) dust mold feathers trees grass weeds other unknown)

Previous skin testing y / n Previous blood testing y/n

Arthritis, Osteo Age Rating #ofMeds #ofHerbs/Suppl

Arthritis, Osteo Chronic y / n Joint replacement y / n after injury y / n FamHist y/n

Arthritis, Rheum. Age Rating #ofMeds #ofHerbs/Suppl

Asthma Age Rating #ofMeds #ofHerbs/Suppl FamHist y / n

Respir.Other Age Rating #ofMeds #ofHerbs/Suppl

Cough Age Rating #ofMeds #ofHerbs/Suppl Chronic y / n

AttentionProb Age Rating #ofMeds #ofHerbs/Suppl Chronic y / n

ADD/ADHD Previous Diagnosis y / n Family history y / n

Cancer Breast/Prostate Age Rating Chemo y / n Radiation y / n FamHist y / n

Surgery y / n Tamoxifen y / n

Cancer Other Age Rating Chemo y / n Radiation y / n FamHist y / n

Chemical Exposure Age Rating

Depression Age Rating #ofMeds #ofHerbs/Suppl

Diabetes Age Rating #ofMeds #ofHerbs/Suppl

Diabetes Diet control y / n Oral Meds y / n Insulin y / n Type I y / n

Diet: (estimate of servings per week) Artificial Sweeteners Cane Sugar Corn,Corn Syrup Dairy

Eggs Soy Wheat Yeast Bread FiveOrMoreServingsFreshFruitsVeg/day y / n

(a serving of sweeteners or sugar would be consuming a food or drink that contains it; a serving of dairy would be ½ cup, eggs—1 egg, soy— ½ cup, wheat—1piece of bread, ½ cup of pasta, yeast bread(regular loaf bread) 1 slice) Fresh fruits and vegetables—1/2 cup = 1 serving

Disk Disease in Spine: Neck (Age)			Mid Back (Age)			Low Back (Age)			
Eczema	Age	Rating	#ofMeds			#ofHerbs/Suppl			
EmotionProblem	Age	Rating	#ofMeds			#ofHerbs/Suppl			
Fainting	y / n	Age	Rating	Chronic y/n	Falling y/n	Age	Rating	Chronic y / n	
Fatigue	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
Fevers	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
Fibromyalgia	Age	Rating	#ofMeds			#ofHerbs/Suppl			
Fracture	Age	Rating	Total number						
GI AbdBloating	Age	Rating	#ofMeds			#ofHerbs/Suppl			
GI Constipatn	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
GI Diarrhea	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
GI GERD	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
GI IrritBowel	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
GI Nausea/Vomiting	Age	Rating	Chronic y / n						
HeadachGenl	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
HeadachMigrn	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
HeadachSinus	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
HeadInjury	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
HeartDisease	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
HerpShingles	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
HerpesOral	Age	Rating	#ofMeds			#ofHerbs/Suppl			Recurr. y / n
HerpesGenitl	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
HighBldPress	Age	Rating	#ofMeds			#ofHerbs/Suppl			
Insomnia	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
LymphNodes	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
Memory	Age	Rating	#ofMeds			#ofHerbs/Suppl			Chronic y / n
Menopause	Age1stSympt.	AgeEndAllPeriods	HRT y / n	HRT Date	HRT #ofYears				
Menopause	Symptoms (circle and use number rating 1-10,10 being worst)								
Bleeding	Concentratn	HotFlash	Mood	Fatigue	JointPain	Memory	WgtGain	Other	
MenopausePresentMeds	y / n	Pharmaceutical	y / n	Bioidentical	y / n				
OralContraceptives	Present y / n	Total number of years _____							

Pain Abd Age Rating #ofMeds #ofHerbs/Suppl Chronic y / n

Pain LoBack Age Rating #ofMeds #ofHerbs/Suppl Chronic y / n

Pain (circle and rate 1- 10) Chest Joint Muscle Neck Sciatic Post-Surgical Other

Psoriasis Age Rating #ofMeds #ofHerbs/Suppl Chronic y / n

Reaction: (circle/underline, rate 1-10) Chemicals Perfumes CleaningSupplies Other

RestlessLeg Age Rating #ofMeds #ofHerbs/Suppl Testing y / n

Seizures Age Rating #ofMeds #ofHerbs/Suppl Chronic y / n

SinusInfex Age Number/Year Rating #ofMeds #ofHerbs/Suppl Recurrent y / n

SinusCongest Age Rating #ofMeds #ofHerbs/Suppl Chronic y / n

SkinRash Age Rating #ofMeds #ofHerbs/Suppl Chronic y / n

SpinalStenos Age Rating #ofMeds #ofHerbs/Suppl

Sprain Age Rating NumberOfSprains Chronic pain y / n

Strep Infex Age Rating Penicill.Resistant? y / n Recurrent y / n

Surgeries (circle, age) Appndx Heart HeartTotal# Colon GallBldr HysterecTotal

HysterecStillHaveOvaries Sinus Spinal Thyroid Tonsils TubesTied Vasect

Stroke Age Total number Rating #ofMeds #ofHerbs/Suppl

ThyroidLow Age Rating #ofMeds #ofHerbs/Suppl

ThyroidHigh Age Rating #ofMeds #ofHerbs/Suppl

Thyroiditis, autoimmune Graves y / n Hashimoto's y / n

Tuberculosis y / n TB Meds (number of months years Interstitial Cystitis y / n

UrinTractInfex Age Rating #ofMeds #ofHerbs/Suppl Recurrent y / n

VaginallInfex Age Rating #ofMeds #ofHerbs/Suppl Recurrent y / n

Vaccination Child y / n Adult y / n Complications y / n

Weight Present weight Loss Past Year Gain Past 10 years RatingAsProblm

Alcohol PrevProb y / n PresentProb y / n Rating Drink per: Day Week Mo <1/mo y/n

Drug PrevProb y / n PresentProb y / n Rating Use: Daily Weekly Monthly

Eating Disorder Age Rating Present problem y / n Meds y / n

Smoking Previous y / n Present y / n Rating Total years Total Pack-years

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FINANCIAL INFORMATION AND AGREEMENT
(Must be signed for forms to be complete)

Our Fees Are As Follows:

Initial Visit-Adult or Child (Consultation with Dr. Howard-1hour)	\$240.00
Food Allergy-Sensitivity Test (Extended Basic Panel Only)	\$225.00
<i>Additional Panels: Nuts, Fruits, Vegetables, Stress Filters, Supplements, etc.</i>	\$25 and up
Single Session Follow-up Visit (30 minutes)	\$110.00
Double Session Follow-up Visit (1hour)	\$220.00

Our office requires payment at the time of service. With most insurance companies, you can expect to be reimbursed for at least a portion of your payment for the consultation by sending in our bill, which has all the necessary information. However, the Allergy Test is not covered under any insurance plans.

We do charge our regular fees if you miss or cancel an appointment with less than 24 hours notice given.

The purpose of this policy is to make appointment times available to our patients. Your appointment time is reserved for you. If you miss it without notifying us, we would be unable to make the time available to another patient who might need it.

Of course emergencies do occur. In these instances, you will not be held responsible for the charges. Cancellations of convenience, or last minute scheduling conflicts will be your responsibility. We will keep credit card information on file as a guarantee of payment.

We remain available to discuss this policy regarding general or individual circumstances. Please sign below and provide the requested credit card information to indicate that you are in agreement with this policy.

Thank you for your cooperation.

MARTHA H. HOWARD, M.D.

_____/_____/_____
Credit Card Number
(all major credit cards accepted except American Express)

_____/_____
Expiration Date

Please Sign Here

_____/_____
Today's Date