Wellness Associates of Chicago 4250 North Marine Drive, Suite 200 Chicago, IL 60613

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, Diptheria, Tetanus, Chicken Pox
Adult Vaccinations (circle or underline) Tetanus Diptheria 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/Supp

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

VaginalInfex 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)

New Patient Fees:

New Patient Consult - Adult or Child ***(Consultation with Dr. Howard ~ 1hour)***	**$240.00**
Initial Comprehensive Allergy Assessment Panels (Initial Testing)	**$250.00**
Additional Panels: Nuts, Fruits, Vegetables, Stress Filters, Supplements, etc.	*$25 and up*
Single Session Follow-up Visit (30 minutes)	*$110.00*

INSURANCE INFORMATION

(MEDICARE DOES NOT COVER OUR SERVICES)

Our office requires payment at the time of service. The Allergy Testing we offer IS NOT covered by any insurance plans. The physician consultation portion can be submitted to the insurance for possible reimbursement. You will receive a bill with all the necessary information to submit to your insurance plan. Reimbursement will depend upon your benefits for an Out-of-Network Provider service.

***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 Expiration Date

(all major credit cards accepted except American Express)

_____ _____/_____/_____

Please Sign Here Today's Date