

George Guess, MD, DHT

233 Hydraulic Ridge Rd, Suite 101
Charlottesville, VA 22901
434-295-0362/fax 434-295-0798
<gguessmd@embarqmail.com>

To Our New Patients,

We would like to take this opportunity to explain some things about our clinical operation. If you have any questions about any aspect of homeopathy or your homeopathic treatment while under our care, please ask. We believe open communication is a necessity between physician and patient. The decision to pursue homeopathic care is yours. Rest assured that your decisions during the course of your treatment will always be respected.

At the beginning of your homeopathic experience it is important to emphasize that homeopathic treatments is best viewed as a process rather than an isolated attempt for a quick cure. Careful monitoring of your progress is required if steady gains are to be achieved. Your homeopathic prescriptions will be adjusted as necessary. Consequently, your follow-up visit(s) are vitally important. The first follow-up is usually scheduled six weeks after your initial consultation. Subsequent follow-ups are individually scheduled based upon need. Often, as one's health improves, the interval between follow-up visits lengthens, ultimately resulting in irregular visits as needed.

Please take the time to thoroughly fill out the enclosed forms and to write a narrative description of yourself and your illness (an instructional guide is enclosed to help you with this). We need this information to assist in helping you.

We do not routinely bill insurance carriers for your treatment. We expect you to be responsible for your bill. We will provide you a superbill to file with your insurance company; usually this procedure is effective in obtaining compensation for our office fees from the insurer. Please note that we do not accept/file for Medicare/Medicaid patients, though we are happy to have you as patients (self pay). If, after reading this information, you have any questions, please call. We are glad to have this opportunity to participate in your health care and look forward to working with you.

Sincerely,

George Guess, MD, DHT

Practice Information

George A Guess, MD, DHt

233 Hydraulic Ridge Rd, Ste 101

Charlottesville, VA 22901

434-295-0362/fax: 434-295-0798

gguessmd@embarqmail.com/www.doctorguess.com

FEE SCHEDULE

Initial 90 minute Homeopathic Medical Consultation

Adults \$345⁰⁰ **Children** (below 7 years old) \$280⁰⁰

Follow-up visits (30 mins.- in person or telephone) \$90⁰⁰

Payment in full is due at the time services are rendered. Cash, check or credit card (MC/VISA) are acceptable. A Superbill with required coded information will be provided to you for submittal to your health insurance company for reimbursement. Installment payment plans are available. Contact our office for more information. Sliding scale fees are also available on request; reduced rates must be pre-approved before the consultation. Ask for an application form if interested.

Please note! New patients are responsible for calling **48 hours** in advance to change or cancel a first appointment; cancellation of scheduled follow-up or acute visits/calls requires **24 hours** advance notice. **We reserve the right to charge in full for scheduled consultations which are missed!** (excepting emergencies, of course.) **Also, there will be a \$35 fee for all returned checks.**

Office Hours: 9:30 a.m. until 5:30 p.m. Monday, Tuesday, Thursday

9:30 a.m. until 4:00 p.m. Wednesday

9:30 a.m. until 3:00 p.m. Friday

Saturday hours are scheduled once per month

Telephone/email Policy: Because of our high volume of telephone service, long-distance calls will, with your permission, be reversed. Unscheduled telephone calls and after-hours emergency calls which are lengthy or result in a homeopathic prescription will be charged on a time basis (\$3.00/minute, \$90 maximum), as will lengthy emails and those requiring a homeopathic prescription. Brief informational calls will not be billed.

After Hours/Weekend Urgent Calls: Please call 434-984-2853

Directions to the Office

From the South: Continue on Route 29N onto Route 250/29 bypass. Continue on this route for 3.7 miles past the I 64 intersection. Exit right at the 29N/Washington exit. Continue straight (north) on 29 for 0.3 mile and turn left at Hydraulic Rd. [At the intersection on the left diagonally across 29 is a 7-11 Store.] Continue on Hydraulic for 1 mile. Turn right onto Hydraulic Ridge Rd (Albemarle Professional Court)* just before the stoplight at Whitewood Rd.

From I-64 East (Richmond) : I 64 West to the first Charlottesville exit - Rt 250 bypass. Go right on Rt. 250. Continue on 250 for 4.4 miles, then exit right at the 29N exit. Continue on 29N for 0.3 mile and turn left onto Hydraulic Rd. [At the intersection on the left diagonally across 29 is a 7-11 Store.] Continue on Hydraulic for 1 mile. Turn right onto Hydraulic Ridge Rd (Albemarle Professional Court)* just before the stoplight at Whitewood Rd.

From I-64 West (Staunton, Waynesboro, & I-81) : I 64 East to the 29North exit (Exit #118B). Go North on 29 (also 250E bypass) for 3.7 miles until you come to the 29N/Washington exit. Exit right and go north on 29 for 0.3 mile and turn left onto Hydraulic Rd. [At the intersection on the left diagonally across 29 is a 7-11 Store.] Continue on Hydraulic for 1 mile. Turn right onto Hydraulic Ridge Rd (Albemarle Professional Court)* just before the stoplight at Whitewood Rd.

From the North: Route 29S toward Charlottesville. Turn right on Hydraulic Road (7-11 on corner on right). Continue on Hydraulic for 1 mile. Turn right onto Hydraulic Ridge Rd (Albemarle Professional Court)* just before the stoplight at Whitewood Rd.

***The Office** is located in the Albemarle Professional Court at 233 Hydraulic Ridge Rd (across from Albemarle High School). Upon turning onto Hydraulic Ridge Rd (into a parking lot) from Hydraulic Rd. turn left immediately into the nearest parking area and park. Our office is in the nearest building on the right hand side on the lower level (Suite 101). We are the first door on the right (to the right of Chiropractic Family Wellness Center).

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A BRIEF SUMMARY OF HOMEOPATHY AND HOMEOPATHIC PRACTICE

What is Homeopathy?

Homeopathy is a medical therapeutic system founded by Dr. Samuel Hahnemann, a German physician, in the early 19th century. It is still practiced today, and, in this age of science and technology, it is a telling testimony to its validity and effectiveness that increasing numbers of doctors trained in orthodox Western medicine are taking up homeopathy. In many parts of the world homeopathy has achieved substantial popularity and governmental support.

The goal of homeopathic medicine is to restore the health of ill individuals *safely, gently and permanently*. The first step is to arrive at a thorough understanding of exactly what constitutes the "disease" from which a person suffers. To do this the homeopathic physician conducts an extremely thorough and lengthy consultation in which not only physical symptoms are elicited, but also mental and emotional factors which may play an important role in the patient's illness.

One of homeopathy's great strengths is that it *views the patient as a whole* and avoids the narrow specialization that characterizes much of orthodox medicine.

What are homeopathic remedies?

Once the homeopathic physician arrives at an intimate knowledge of the illness, he then attempts to treat the patient, when appropriate, by orally administering a single select homeopathic medicine, called a remedy. Where indicated, he may also make recommendations about diet, exercise, life style, etc.; however, the prime focus of the system of homeopathic therapeutics is the prescription of the homeopathic remedy.

Homeopathic medicines are prepared from a wide range of substances--animal, vegetable and mineral. Their preparation involves a process of sequential dilution in alcohol/water and succussion (vigorous shaking), a process known as potentization. This process of potentization enables the homeopath to prescribe medicines which possess an enhanced curative effectiveness and essentially no toxic side effects, unlike current orthodox drugs.

What is the Law of Similars?

What really distinguishes homeopathy from orthodox medicine is the basic principle upon which homeopathic physicians choose the indicated medicine. This principle is called the Law of Similars, which says: a substance that can produce symptoms in a healthy person can cure the same combination of symptoms in a sick person.

What is the philosophy of homeopathy?

Homeopathy recognizes that the human organism possesses an intelligence that directs all of its functions in health and in disease. When we fall ill as a consequence of some life stress (dietary, environmental, hereditary, psychological), specific and unique symptoms are produced in each individual.

Homeopathy asserts that such symptoms are expressions of the organism's effort to heal itself, to overcome the stress. For example, when we contract a cold, the immune response--fever, runny nose, sore throat, cough, etc.--results because it is the best way in which our body can rid itself of the responsible cold virus. In the homeopathic treatment of a cold or any other problem, acute or chronic, a remedy is prescribed which is intended to enhance the patient's own healing effort. In this way, the patient's vitality may be strengthened, and the disease should be overcome gently and safely. The final goal of homeopathic medicine is the restoration of total health--mental, emotional and physical.

What can homeopathy treat?

While there are homeopathically incurable patients, there are few "disease categories," per se, that are not responsive to homeopathic treatment. A wide range of problems fall within the province of homeopathy, including gastrointestinal, immune (allergies, etc.), metabolic, hormonal, menstrual, infectious and emotional disorders. Both acute (such as colds and flus) and chronic health problems may be treated, and homeopathic patients can be of any age. Ask your homeopathic physician whether or not homeopathic treatment is appropriate for your condition.

In summary...

Homeopathy is an extremely safe and effective alternative medical discipline. Because of its efficacy and the relative infrequency of visits required compared to many other therapies, homeopathy is also the most cost effective, inexpensive medical therapy available. In addition, many health insurance carriers will cover the cost of homeopathic health care.

PATIENT INFORMATION

NAME: _____

Referred by: _____

ADDRESS: _____

AGE: _____

DATE of BIRTH _____

SEX _____

MARITAL STATUS: S M W D SEP

PHONE (home): _____

CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

SOCIAL SECURITY #: _____

Driver's License (state)#: _____

SPOUSE'S EMPLOYER: _____

ADDRESS: _____

PHONE: _____

PERSON RESPONSIBLE FOR PAYMENT (if other than the above): _____

ADDRESS: _____

PHONE: _____

SOCIAL SECURITY #: _____

EMPLOYER/ ADDRESS/PHONE: _____

I assume full financial responsibility for the cost of homeopathic medical services provided by Dr. Guess.

Date: _____

Signed: _____

(Patient, Parent or Guardian)

Responsibility for Payment for Missed Appointments

Please note that it is your responsibility to cancel any appointment with Dr. Guess that you are unable to keep. As mentioned in our Practice Information sheet, cancellations of any follow-up or acute appointment must be done at least 24 hours in advance. Failure to notify the office at least 24 hours before the scheduled appointment will result in your being billed for the full amount of the appointment – usually \$80 (unless an extended visit was scheduled).

To insure that such fees can be collected, we require a valid credit card number (and expiration date) for each patient to keep on file. Your card will not be billed excepting for missed appointments and, in some cases, delinquent accounts. We will notify you should your card be billed for the above reason(s).

Please sign the following statement.

I have read the foregoing and agree to assume responsibility for any fees resulting from appointments I miss and/or fail to cancel with at least 24 hours prior notice.

_____ (signature)

Date _____

Credit Card Information:

(Only Mastercard or Visa accepted)

Card Number: _____ Expiration: _____

About Delinquent Accounts

We will make every effort to meet you half-way if you are having trouble paying your bill; so please call us if you require special consideration. Accounts 90 days past due, with no payment activity registered during that time, will be turned over to collections. Once turned over to the collection agency, the amount due will be increased by 50% to cover the cost of collection.

Please initial below, signifying that you understand this collection policy.

_____ (your initials)

HOW TO REPORT SYMPTOMS

Directions: Please respond to the following on separate pages of paper. Try to condense your reporting such that you don't exceed 4-5 pages (typed) total; if you have to go over that limit, fine. Brevity, though, will help focus your report on the essentials.

1 Chief Complaint: Describe your chief complaint – your main reason for coming for the consultation – in full detail; ie, when and how it began, its diagnosis (if you have one), all signs (physical changes) and symptoms/sensations associated with it, referring to the descriptive headings below (if a skin complaint, also refer to item 7 below):

- a. Quality of pain/sensation (eg, dull, ache, pulsating/throbbing, burning, cutting, stitching, numbness, tingling, crawling, coldness, heat, etc.)
- b. Location of pain/sensation.
- c. Does the pain/sensation extend to another part of the body?
- d. What makes the pain/sensation feel better or worse (homeopaths call these modalities)?
 - Heat or cold (air temperature, room temperature, applications, baths)?
 - Weather or weather changes?
 - Time of day or night?
 - Position (standing, sitting, lying – in what position, etc.)?
 - Activity (walking, running, driving/riding, bending, rising, ascending or descending stairs, reaching, turning, lifting, sleeping, waking, jarring, etc.)?
 - Touch, rubbing, pressure (hard or light, clothing)?
 - Eating or drinking (if so, what in particular – hot/cold drinks, type of food)?
 - Bodily functions (menstrual period, sweating, salivating, urination, defecation, coughing, sneezing, etc.)?
 - Other exposures (light, sunlight, noise, odors, music, conversation)?
- e. And, finally, are there any associated symptoms/conditions that tend to occur with the complaint (homeopaths call these “concomitants”)? Examples: abdominal bloating, salivation, chills, etc.

Comment on the previous treatment this complaint (and others) has received.

2 Past Medical History: Mention all previous illnesses. A complete history of your health is important, even of such things as skin diseases, children's diseases and their after-effects; tell of fevers, colds, flus, sores, ulcers, etc.; also injuries, if any. Tell their location and what treatment was used.

3 Additional Complaints: Describe all additional health complaints – you may reserve mental-emotional complaints for a later section, and provide all relevant details (modalities, etc) of each as requested for the chief complaint. Also, describe how your sense of vitality, well-being is, your energy level and what affects it for the better or worse.

4 Mental-Emotional Characteristics

If mental-emotional distress troubles you, please provide as full a description as you can, mentioning how you feel, how the problem seemed to begin and the apparent cause, what makes you feel better or worse (this could be any of the modalities mentioned in item 1 or it could consist of other influences; eg, consolation, company, being alone, anger, specific types of stress, overwork, humiliation, criticism, etc.)

Tell of any emotional shocks, frights, disappointments, etc. of the present or past.

Provide a thorough description of yourself – your character and personality, as best you can. For example, are you outgoing or introverted, a loner or quite sociable, shy, timid, confident, assertive, arrogant, calm, angry, aggressive, anxious, melancholy, moody, cheerful, humorous, serious, talkative, quiet, industrious, impatient, hurried, lazy, slow, content or discontent, easily offended and sensitive to criticism or impervious to same, engaged and curious, neat or sloppy, bored and indifferent - whatever you can think of. If you have trouble thinking of things to say, try to recall what friends and family have said about you, or even ask them to write-up their own description of you.

Have you any fears? For example, heights, claustrophobia, darkness, robbers, animals, insects, snakes, water, storms, airplanes, crowds, sight of blood, public speaking, death, disease, germs, being alone, performing, rejection, criticism, death of a loved one, horrible/violent sights (real or in the media), etc.

How is your mental functioning and memory?

How do you feel about your work/career/school?

How do you feel about your relationships/marriage/family?

What are your dissatisfactions in life, your goals, your joys?

What do you like least/most about yourself?

What are your favorite hobbies or pastimes (eg, crafts, music, reading, travel, sports, etc)?

5 Generalities: “Generalities” is the term homeopaths apply to the modalities of the whole person, as opposed to specific complaints. Using all the modality descriptors listed in item 1, comment upon how you as a person, in general are affected by various influences, stimuli, and activities, if remarkable. For example, are you chilly or warm-natured; affected by weather or storms (approaching or present), drafts, sunlight, clouds, humidity; affected much by eating or drinking; by time of day or night; perspiration; getting wet; menstrual period; resting; activity; exercise; occupation; thinking; meditating; the ocean or mountains. Do any of these or anything else make you feel significantly better or worse?

6 Food/Drink

How strong or weak is your appetite and thirst? Do you get hungry or thirsty at any specific or unusual time?

Tell what is strongly craved or disliked, including such things as salt, sweets, fats, sour, spicy things, eggs, milk, cheese, ice cream, chocolate, meats, fish, chicken, fruits, vegetables, onions, garlic, soup, ice, cold things, warm things, bread, etc. Also, what drink is preferred?

7 Skin: In skin, scalp, or nail problems, tell the exact location, color, whether dry or moist, thick or thin, scaly, crippled, pimply, with or without matter, warts or growths, appearance of surrounding skin; whether itching, burning, worse or better from scratching, and what else makes it better, such as heat, the heat of the bed, cold, exercise, wool, water, etc. Tell of any enlarged veins, unusual bruising, etc.

8 Discharges: Describe discharges of any part, whether slight or heavy, the color, odor; if thick or thin, gluey or sticky; if causing redness or burning, rawness; color or stain; and what makes it better or worse and when.

9 Urine: Is there urinary tract pain before, during or after passing, color, odor, appearance, quantity, sediment, frequency, urgency (if hurried).

10 Bowel condition/Elimination: What is the stool’s appearance: color, odor, consistency (hard, dry, large, pasty, bloody, frothy, slimy, thin, watery, slender, flat, etc.)? How often, at what times worse or better, or how affected by certain circumstances; whether difficult, incomplete, urging without result; if the stool slips back in, if prevented by spasm of the rectum; or anything else peculiar.

11 Menstrual History: Woman are to give age at first menstrual period, how far apart then and now; whether pain before, during, or after, then and now, and where; also where the pain may extend to, as to the back, sides, groins, thighs, etc. What kind of pain), what relieves or aggravates, how often the pains come. If you have experienced PMS (premenstrual syndrome), please describe all of the symptoms associated with it. Tell whether there have been miscarriages. Tell how you feel in general, before, during and after the periods; sex desire or aversion, frequency of masturbation (at your discretion, of course), whether intercourse is normal, unsatisfactory, or painful; masturbation frequency, etc. Please also describe how any past pregnancies affected you.

12 Males: Men are to give particulars as to male organs, if anything is not normal; whether there’s been a history of any former disease; effect of intercourse; strength of sexual drive; frequency of masturbation (at your discretion, of course); whether night emissions, etc.

13 Sleep: Describe the details of your sleep. Do you sleep well or poorly? Do you have trouble falling asleep or staying asleep? Do you waken at a certain hour? In what manner; e.g., as from fright, from a dream, from a sensation of heat, from a physical pain or other sensation? In what position do you sleep? Do you stay covered or uncover? Do you uncover your feet at night? Are there any peculiarities associated with sleep, such as teeth grinding, perspiration, salivation (drooling), jerking, restlessness, talking or walking? Do you dream? Do you have any recurring dreams or dreams of a similar nature; i.e., similar theme, same object or person recurringly appears, etc.? Mention any other peculiarities of sleep. How do you feel on waking in the morning?

14 Summary: Lastly, but most importantly, if you are willing, using the guidelines given above, please write a narrative summarizing your principle complaints and the "reason" you think you became ill. Do you think your life situation at the time or now, any stress you may have been exposed to, any qualities in yourself might have contributed to your illness. Similarly, did any physical, chemical, or biologic trauma contribute? Describe the significance of your illness to you, what your emotional reaction to it is, what your worries in regard to it are. And also, describe yourself (separate from the illness), what you feel are your central personal strengths and weaknesses; include a summary of your life history focusing upon the most important events in your life – major griefs and losses, disappointments, the worst thing(s) that has happened to you, your childhood. There may be overlap with your answers to item 4 above, in which case there's no need to repeat yourself here. Discuss what is most important to you in life.

And that's all! Whew! We know what an effort it is to describe yourself and your symptoms in the details necessary for a homeopathic interview, and we appreciate your labours. This will greatly assure us that some important detail has not been left out. When you arrive at the office, Dr. Guess will review your write-up before conferring with you in person, a process that usually takes about thirty minutes or so. Thank you.

Homeopathic Treatment Consent Form

I, _____, by signing this document, hereby authorize Dr. George Guess to treat me/my child (_____), using homeopathic medicines and according to the tenets of homeopathic practice. I understand and acknowledge that Dr. Guess will base his treatment decisions on the school of homeopathic practice, and if I desire to be treated according to the orthodox or allopathic school of medicine, I will seek any such treatment from another physician.

Dr. Guess has made no guarantees to me that his homeopathic treatment will cure me, and I acknowledge that he has explained to me the principles of homeopathy and treatment by homeopathic means.

signature of patient or parent/guardian

Satisfaction Questionnaire

We would very much like to know of your impressions of our practice. After a couple of months pass, please take a few moments to fill out the questionnaire below. You can do so confidentially. Your responses will help us serve you better. Thank you.

Your name (optional) _____ Your age? _____ Sex? _____
 Marital Status? _____ How long have you or your child been a patient? _____

Please indicate your opinion of the following by circling the appropriate number according to the scale below.

very satisfied	somewhat satisfied	somewhat dissatisfied	very dissatisfied
4	3	2	1

1. Facilities

- | | | | | |
|----------------------------------|---|---|---|---|
| a. Convenience of location | 4 | 3 | 2 | 1 |
| b. Appearance of building | 4 | 3 | 2 | 1 |
| c. Appearance of office upstairs | 4 | 3 | 2 | 1 |
| d. Accessibility for disabled | 4 | 3 | 2 | 1 |
| e. Comfortable waiting area | 4 | 3 | 2 | 1 |
| f. Appearance of waiting area | 4 | 3 | 2 | 1 |

2. Access to Appointment/Care

- | | | | | |
|---|---|---|---|---|
| a. Phone answered promptly | 4 | 3 | 2 | 1 |
| b. Appointment scheduled in courteous fashion | 4 | 3 | 2 | 1 |
| c. Convenient appointment time | 4 | 3 | 2 | 1 |
| d. After hours response prompt | 4 | 3 | 2 | 1 |

3. Staff Contact

The receptionist:

- | | | | | |
|--|---|---|---|---|
| a. Seemed concerned and caring | 4 | 3 | 2 | 1 |
| b. Was competent and efficient | 4 | 3 | 2 | 1 |
| c. Was neat and professional in appearance | 4 | 3 | 2 | 1 |
| d. Respected my confidentiality | 4 | 3 | 2 | 1 |
| e. Provided accurate, helpful information | 4 | 3 | 2 | 1 |
| f. Answered my questions | 4 | 3 | 2 | 1 |
| g. Responded to my calls promptly | 4 | 3 | 2 | 1 |

4. Visit with Dr. Guess

Dr. Guess:

- | | | | | |
|--|---|---|---|---|
| a. Seemed concerned and caring | 4 | 3 | 2 | 1 |
| b. Thoroughly took my case history | 4 | 3 | 2 | 1 |
| c. Spent enough time with me | 4 | 3 | 2 | 1 |
| d. Explained my homeopathic treatment plan | 4 | 3 | 2 | 1 |

5. Follow-up

- | | | | | |
|---|---|---|---|---|
| a. My phone calls were returned promptly. | 4 | 3 | 2 | 1 |
| b. I feel I was helped by my homeopathic treatment. | 4 | 3 | 2 | 1 |

6. Billing

- | | | | | |
|--|---|---|---|---|
| a. Fees were clearly explained to me | 4 | 3 | 2 | 1 |
| b. Fees were appropriate for the care I received | 4 | 3 | 2 | 1 |
| c. My insurance billing was successful | 4 | 3 | 2 | 1 |

7. Special needs not met by the practice were:

8. Things I especially like about the practice are:

9. Other comments:

HEALTH HISTORY QUESTIONNAIRE

NAME: _____

DATE: _____

FAMILY HISTORY								
For each member of your family read down the list of diseases and put a check in the boxes which apply. Put one check for each relative having a certain disease; ie, put 3 checks in grandparents-stroke if 3 of your grandparents suffered strokes. Indicate age only if relative is deceased.								
	father	mother	grandparents	brothers	sisters	children	spouse	aunts/uncles
Age (at death only)								
Cause of death								
Cancer								
Tuberculosis								
Diabetes								
Heart trouble								
High blood pressure								
Stroke								
Allergies or asthma								
Anemia/blood disease								
Mental illness								
Genetic disease								
alcoholism, drug abuse								
Kidney disease								
arthritis, autoimmune								
Venereal disease								
Malaria								

PERSONAL HISTORY

Put a check next to any of the following that you now have or have ever had:

- | | | | | | |
|--|--|---|---|--|---------------------------------------|
| <input type="checkbox"/> measles | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> serious injury | <input type="checkbox"/> sinusitis | <input type="checkbox"/> migraines | <input type="checkbox"/> hypertension |
| <input type="checkbox"/> mumps | <input type="checkbox"/> bronchitis | <input type="checkbox"/> jaundice | <input type="checkbox"/> hay fever | <input type="checkbox"/> anxiety | <input type="checkbox"/> rabies |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> pneumonia | <input type="checkbox"/> malaria | <input type="checkbox"/> frequent colds | <input type="checkbox"/> depression | <input type="checkbox"/> reactions to |
| <input type="checkbox"/> polio | <input type="checkbox"/> pancreatitis | <input type="checkbox"/> liver disease | <input type="checkbox"/> neuritis | <input type="checkbox"/> serious | drugs, vaccines, |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> ulcers | <input type="checkbox"/> skin disorders | <input type="checkbox"/> sciatica | <input type="checkbox"/> infection | transfusions |
| <input type="checkbox"/> small pox | <input type="checkbox"/> diverticulosis | <input type="checkbox"/> kidney disease | <input type="checkbox"/> back pain | <input type="checkbox"/> alcoholism or | to what? _____ |
| <input type="checkbox"/> meningitis | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> or stones | <input type="checkbox"/> anemia/blood | <input type="checkbox"/> drug abuse | other _____ |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> arthritis | <input type="checkbox"/> venereal disease | <input type="checkbox"/> disease | <input type="checkbox"/> hyperactivity | _____ |
| <input type="checkbox"/> hernia | <input type="checkbox"/> cancer | <input type="checkbox"/> concussion or | <input type="checkbox"/> asthma | <input type="checkbox"/> heart trouble | _____ |
| <input type="checkbox"/> genetic disease | <input type="checkbox"/> bone or joint | <input type="checkbox"/> head injury | <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke | _____ |
| | disease | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> headaches | <input type="checkbox"/> rheumatic fever | |

MAJOR HOSPITALIZATIONS			
If you have ever been hospitalized for any serious illness or operation, write in your most recent hospitalizations below. Use reverse side if needed. (Do not include normal pregnancies.)			
YEAR	OPERATION OR ILLNESS	PHYSICIAN'S NAME	CITY AND STATE

Please list the name and address of any other physicians who have treated you in the last five years and the problem you were treated for. (Do not include visits for colds, flus or other minor acutes.)

PHYSICIAN'S NAME	ADDRESS	PROBLEM

MEDICATIONS

Indicate those medicines you are presently taking or which you have taken in the past; please give the name and dosage of all current medicines.

<u>Present</u>	<u>Past</u>		<u>Present</u>	<u>Past</u>	
_____	_____	Antibiotics _____	_____	_____	Diabetes medicine _____
_____	_____	Pain medicine _____	_____	_____	Arthritis medicine _____
_____	_____	Diuretics _____	_____	_____	Diet pills _____
_____	_____	Sedatives _____	_____	_____	Antacids/laxatives _____
_____	_____	Blood pressure medicine _____	_____	_____	Allergy/sinus medicine _____
_____	_____	_____	_____	_____	Birth Control Pills _____
_____	_____	Heart medicine _____	_____	_____	Hormones _____
_____	_____	_____	_____	_____	Antimalarials _____
_____	_____	Thyroid medicine _____	_____	_____	Antituberculosis _____
_____	_____	Aspirin _____	_____	_____	Allergic desensitization _____
_____	_____	Vitamin supplements _____	_____	_____	Other _____

DRUG ALLERGIES

Please list any and all medicines you are allergic to; e.g., penicillin, sulfa drugs, other antibiotics, aspirin, codeine, etc.:

TESTS AND IMMUNIZATIONS

Check those tests and immunizations you have had. Enter the year when you last were given the tests or shots.

__ 19__ Chest X-Ray	__ 19__ Sigmoidoscopy	__ 19__ DPT or DPaT
__ 19__ Kidney X-Ray	__ 19__ PAP smear	__ 19__ Tetanus
__ 19__ GI Series	__ 19__ Nutritional Analysis	__ 19__ Flu Shot
__ 19__ Colon X-Ray	__ 19__ Polio Series	__ 19__ Pneumonia Shot
__ 19__ Electrocardiogram	__ 19__ Measles, mumps, rubella	__ 19__ Other
__ 19__ TB test	__ 19__ Hib Vaccine	
__ 19__ CT or MRI Scan	__ 19__ Ultrasound	

HEALTH FACTORS

Yes	No		Yes	No	
_____	_____	Do you drink:	_____	_____	Do you use an electric blanket
_____	_____	Coffee? ___ cups/day	_____	_____	Do you have silver-mercury amalgam fillings
_____	_____	Tea? ___ cups/day	_____	_____	in your mouth?
_____	_____	Sodas? ___ 12 oz. cans/day	_____	_____	Do you exercise regularly?
_____	_____	Do you drink:	_____	_____	How much? _____
_____	_____	Beer? ___ cans, bottles/day	_____	_____	Do you meditate regularly?
_____	_____	Wine? ___ glasses/day	_____	_____	Do you use "recreational" drugs; e.g., cocaine,
_____	_____	Other alcohol? ___ drinks/day	_____	_____	LSD, marijuana. etc.? How much; how often?
_____	_____	Do you use tobacco?	_____	_____	_____
_____	_____	Cigarettes? ___ packs/day	_____	_____	Have you any known environmental sensitivities
_____	_____	Cigars? ___ cigars/day	_____	_____	or past or present toxic chemical exposures?
_____	_____	Pipe? ___ bowls/day	_____	_____	Please describe: _____
_____	_____	Chew? ___/Snuff? ___			