

CENTER FOR PREVENTIVE MEDICINE

Gail D. Vanark, MS, FNP, BC

3 Overlook Dr., Suite 1

Amherst, NH 03031

Ph. (603) 673-7910 Fax (603) 673-7991

Welcome to our office. We are happy that you have chosen to come to us for your complementary health care. Our office policies are designed to assure that we are able to provide the quality of care you expect from us, and that all of our patients are able to receive their care promptly, with minimal waiting times. This letter explains our office policies. Please take the time to read it, sign it, and give it back to the staff when you come for your visit. We look forward to meeting you.

The undersigned acknowledges that he/she has requested healthcare services from Center for Preventive Medicine. Many of the therapies offered at the Center are considered unconventional by the mainstream medical establishment. Although some treatments have been in continuous use for a long period of time, they have been deemed "unproven" by such organizations as the American Medical Association, the Food and Drug Administration and certain insurance companies. Any therapy suggested to you can, of course, be refused and/or terminated at any time to receive only conventional therapies without the use of alternative or complementary modalities. Under no circumstances are you obligated to accept any treatment offered to you.

Disclosure of Information

All information provided to Center of Preventive Medicine staff and clinicians is strictly confidential except for the following circumstances:

Your insurance company requests information about your treatment in order to process a claim or certify care.

The patient authorizes the release of information by signing a release form naming the specific person to receive the information.

Certain circumstances where we are required by law to release information (e.g. court subpoena, suspected abuse, etc.)

Financial Terms

You are expected to pay for your care in full at the time services are rendered. We will provide you with a universal health insurance claim form so that you may submit a claim to your insurance company for reimbursement. We do not participate with any insurance companies, and do not submit insurance claims. If an amount owed by a patient is not received on a timely basis, the patient may be responsible for reasonable attorney fees and the cost of collection. There is a \$15 charge for copying medical records, and there is a \$25 fee for returned checks.

Canceled/Missed Appointments and Late Arrivals

When you make an appointment, we are reserving time on a practitioner's schedule that is no longer available to other patients. We do require a \$100 deposit for all new patient appointments, which will be applied to the first visit. If you cannot make an appointment, we ask that you cancel your appointment at least 24 hours in advance. A new patient deposit will be refunded if you give 24 hours advance notice of a cancellation. The Center's voice mail message center 603-673-7910 accepts messages about appointment cancellations at any time (24 hours/day).

Late arrivals can create scheduling problems with other patients. If you must be late, please call to let us know. If you arrive more than 15 minutes late, we may not be able to accommodate your appointment without interfering with the scheduled times of other patients.

Acknowledgement and Agreement

I have read the above information and thoroughly acknowledge, understand, and agree to all of the above information, including the financial terms as stated above.

Patient (or parent/guardian) PRINTED

Signature

Date

MEDICAL AND HEALTH HISTORY

NAME: _____ **AGE:** _____ **BIRTHDATE:** / / **SEX** M / F
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
PHONE: (H) _____ **(W)** _____ **(C)** _____
E-MAIL: _____ **OCCUPATION:** _____
SS# _____ **How did you hear of us?** _____
Family status: Single / Divorced / Married / Widow(er) / Significant other (circle one)
Emergency contact: _____ **Phone #:** _____

Insurance Company: _____ **Policy #:** _____
Insured's Name (policy holder): _____ **Group name or #:** _____

Chief Complaint

Please list your major problems and/or symptoms and the approximate date it began (If none, please write your reason for seeking this consultation). Please rank in order of importance to you.

	When problem began
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

What are your expectations regarding what you would like our office to provide for you?

If you have seen other practitioners for these problems, indicate the results of these evaluations: _____

MEDICAL HISTORY

Please indicate if **you** or any **family members**, or grandparents, have ever had any of the following problems. Specify who, **including yourself**.

Alcoholism _____

Allergies _____

Anemia _____

Arthritis _____

Asthma _____

Bleeding/bruising _____

Cancer _____

Convulsions/epilepsy _____

Crohn's disease/colitis _____

Diabetes _____

Digestive disease _____

Herpes or shingles _____

Hypoglycemia _____

Drug problems _____

Eczema/psoriasis _____

Heart disease _____

Hepatitis _____

High blood pressure _____

High cholesterol _____

Frequent infections _____

Urinary infections _____

Lupus _____

Mental illness _____

migraines _____

Pneumonia _____

Polio _____

Prostate problems _____

Rheumatic fever _____

Rheumatoid disease _____

Sinus disease _____

Strokes _____

Thyroid problems _____

Tuberculosis _____

Ulcers _____

Venereal disease _____

Weight problems _____

Comments/explanations _____

Family History: List family members, their **ages** or, if deceased, their age at death, and any **medical problems** they have now or have ever had.

Mother _____

Father _____

Grandmother _____

Grandmother _____

Grandfather _____

Grandfather _____

Siblings _____

Children _____

Your tests: specify when, if known

Last physical exam _____

X-rays _____

GI series _____

Gall bladder tests _____

Kidney/bladder series _____

EKG _____

Stress EKG _____

Angiogram/catheterization _____

Ultrasound tests _____

Blood tests _____

Other tests _____

Your immunizations: specify when, if known

Smallpox _____ tetanus _____

Polio _____ flu _____

Mumps _____ measles _____

Pneumonia _____ diphtheria _____

Pertussis _____ other _____

Hospitalization and Surgeries (dates / type)

Do you have a primary care provider?

Yes [] No []

If YES, please complete provider's information:

Name: _____

Address: _____

Phone: _____

Current Medications

Please write the name, dosage and how often taken.

1. _____ 7. _____

2. _____ 8. _____

3. _____ 9. _____

4. _____ 10. _____

5. _____ 11. _____

6. _____ 12. _____

Please list any medications you may have an allergy to and the type of reaction.

Lifestyle and Habits

Tobacco:

Do you currently smoke? _____ **Chew?** _____

If yes, How much per day? _____ **For how long?** _____

If no, Did you ever smoke? _____ **For how long?** _____

When did you stop? _____

Alcohol: (Includes wine, beer, and liquor) **How often do you drink:**

[] Never [] Less than 1 time per week [] 2—5 times per week [] At least once daily

What do you drink? _____

Was drinking ever a problem? _____

Caffeine: **How many cups of the following do you consume daily?**

Coffee _____ Black Tea _____ Green Tea _____ Cola _____

Diet Cola _____ Chocolate _____

Recreational Drug Use (type/frequency) _____

Over the Counter Medications (type/frequency) _____

SYMPTOM AND SYSTEM REVIEW: Write all the appropriate letters in the left hand columns.

DO NOT fill in anything if the problem does not apply to you.

Write “**C**” for a **current** problem; “**I**” if it is an **intermittent** problem; “**P**” for a **past** problem

- | | | |
|------------------------------------|-------------------------------------|---------------------------------|
| _____ headaches | _____ high blood pressure | _____ weakness |
| _____ neck lumps or swelling | _____ skipped heartbeats | _____ painful feet |
| _____ loss of balance | _____ racing heart | _____ leg cramps |
| _____ dizzy spells | _____ chest pain or pressure | _____ trembling or tremors |
| _____ vertigo | _____ swollen feet or ankles | _____ seizures or epilepsy |
| _____ blackouts or fainting | _____ difficulty breathing at night | _____ numbness or tingling |
| _____ blurry vision | _____ varicose veins or phlebitis | _____ skin tumors |
| _____ double vision | _____ recurring indigestion | _____ dry skin |
| _____ cataracts | _____ nausea or vomiting | _____ acne |
| _____ eye pain or itching | _____ intestinal gas/flatulence | _____ eczema |
| _____ watering eyes or redness | _____ belching | _____ skin rashes |
| _____ hearing difficulties | _____ bloating | _____ psoriasis |
| _____ earaches or drainage | _____ abdominal pain or cramps | _____ dandruff / seborrhea |
| _____ noises or ringing in ears | _____ constipation | _____ hives |
| _____ recurrent ear infections | _____ diarrhea or loose stools | _____ itching or burning skin |
| _____ dental problems/decay | _____ rectal itching | _____ easy bruising |
| _____ sore or bleeding gums | _____ blood with stools | _____ hypothyroid (low) |
| _____ sore tongue | _____ black stools | _____ hyperthyroid (high) |
| _____ coated tongue | _____ pain in rectum | _____ weight gain |
| _____ loss of taste or smell | _____ jaundice | _____ weight loss |
| _____ sores in or around mouth | _____ hepatitis/pancreatitis | _____ feel excessively warm |
| _____ difficulty swallowing | _____ colitis | _____ feel excessively cold |
| _____ cold sores or fever blisters | _____ Crohn’s disease | _____ loss of appetite |
| _____ sinus or nasal congestion | _____ diverticulitis/diverticulosis | _____ constant hunger |
| _____ runny nose | _____ frequent urination | _____ fatigue or weariness |
| _____ frequent colds | _____ brown or red urine | _____ night sweats |
| _____ nasal polyps | _____ decreased force of urine | _____ diabetes |
| _____ sore throats | _____ continual urge to urinate | _____ low blood sugar |
| _____ swollen glands | _____ involuntary escape of urine | _____ nervousness or anxiety |
| _____ recurrent fevers or chills | _____ difficulty starting urination | _____ depression |
| _____ hoarse voice | _____ kidney or bladder infection | _____ suicidal thoughts |
| _____ shortness of breath | _____ venereal disease | _____ sought psychological help |
| _____ wheezing or gasping | _____ osteoporosis | *** <u>MEN ONLY</u> *** |
| _____ coughing | _____ aching muscles or joints | _____ painful testicles |
| _____ coughing blood | _____ arthritis | _____ hernia |
| _____ chest colds or pneumonia | _____ joint stiffness | _____ prostate problems |
| _____ heart murmur | _____ back or neck pain | _____ sexual dysfunction |

Female Health History Questionnaire

Name _____ Age: _____ Today's date: _____

D.O.B. _____ Weight: _____ Height: _____ Occupation: _____

What is the reason for your visit?

List any medications you are currently taking:

List any natural supplements or remedies you are currently taking:

1. At what age did you begin menstruating (onset of menarche)? _____
 - a. Number of days of cycle: _____
 - b. How many days of bleeding: _____
2. Have you ever been pregnant: Y / N How many times: _____
3. Do you have children? Y / N
 - a. How many? _____ Ages _____
4. Have you had any miscarriages or ectopic pregnancies? Y / N When? _____
5. Have you used oral, injected, or patch contraceptives? (Circle those that apply)
 - a. When & How Long? _____
 - b. For what reason? _____

6. Do you have any discomfort, PMS, or other symptoms around the time of your period?

7. Bleeding problems:
- a. Heavy bleeding Y / N If yes, how many days? _____
(Heavy bleeding is indicated if you saturate tampons or pads more than 4 times per day)
 - b. Spotting Y / N If yes, how many days? _____
 - c. Clotting Y / N
 - d. Cramping Y / N If yes, when? _____
 - e. Other _____
- _____

Female Health History Questionnaire

(continued)

8. List GYN procedures or surgeries: Ovaries, hysterectomy, breast, other – When and Why:

9. Significant health problems: _____
a. Illnesses _____
b. Surgical procedures _____
c. Hospitalizations _____
d. Other _____
10. Do you drink more than 2 alcoholic beverages per day? _____
11. Do you smoke? _____ How much? _____

Place a check next to the symptoms that apply to you.

1. _____ Mood swings _____ Mild _____ Moderate _____ Severe
2. _____ Irritability _____ Mild _____ Moderate _____ Severe
3. _____ Anxiety; Nervous tension _____ Mild _____ Moderate _____ Severe
4. _____ Short fuse _____ Severe Temper _____ Rage _____ Aggression
5. _____ Overly Sensitive
6. _____ I take care of everyone else in my life before myself
7. _____ Depression _____ Mild _____ Moderate _____ Severe
8. _____ Lessened self-esteem or self-image
9. _____ Sadness _____ Crying
10. _____ Bloating _____ Water Retention
11. _____ Memory difficulties _____ Foggy thinking _____ Lack of concentration
12. _____ Sweet cravings, Carbohydrate cravings, chocolate cravings worse before menses
13. _____ Candida (yeast infections)
14. _____ Hypoglycemia
15. _____ Hyperglycemia (Diabetes)
16. _____ Weight gain _____ Overweight
17. _____ Weight loss
18. _____ Fatigue
19. _____ Cold hands and feet
20. _____ Change in bowel habits _____ Constipation _____ Diarrhea
21. _____ Muscle/joint aches and pains
22. _____ Back ache
23. _____ Headaches/Migraines
 a. When & How often _____
 b. Are they at specific times in your cycle? _____
24. _____ Nausea; vomiting
25. _____ Acne _____ Oily skin

Female Health History Questionnaire

(continued)

26. _____ Excessive facial hair _____ Excessive body hair
27. _____ Change in libido _____ Decreased _____ Increased
28. _____ Difficulty sleeping _____ Insomnia
29. _____ Hot flashes
30. _____ Night sweats
31. _____ Dry eyes
32. _____ Vaginal dryness _____ Painful intercourse
33. _____ Urinary frequency _____ Urinary Incontinence
34. _____ Any other related symptoms or concerns not covered above?
-
-
-
-
-

Menopausal Women

1. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Y / N
If yes, what were you prescribed?
_____ What dosage? _____ For how long? _____
2. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? Y / N
If yes, what? _____
What dosage? _____ For how long? _____
3. Have you utilized any alternative, complementary, or natural remedies in your management of menopause?
Y / N If yes, what? _____
For how long? _____
4. Have you had, or do you have any vaginal spotting or bleeding since menopause? Y / N
If yes, when? _____ Were you evaluated and or treated by a GYN? Y / N
Treatment: _____

Please describe your cycle history.

1. How would you have described your menstruation?
Easy Uncomfortable Difficult Debilitating
2. What was your typical menstrual flow? Light Medium Heavy
3. When you were cycling would you consider your cycle regular? Y / N
If no, explain.
-
-
-

Please describe any "treatment" ever received for cycle issues.

Female Health History Questionnaire

(continued)

Sleep Habits

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia
 How long has this been happening _____
2. How many hours do you sleep a night on average? _____
3. Do night sweats wake you up? Yes No How often? _____
4. Do you wake up tired? Yes No How long has this been happening? _____
5. Is your room completely dark when you sleep at night? (*no night light, street lamp, TV, etc.*) Yes No
6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

Male Health History Questionnaire

Name _____ Age: _____ Today's date: _____

D.O.B. _____ Weight: _____ Height: _____ Occupation: _____

1. What is the reason for this visit?

2. List medications you are currently taking:

3. Any known drug allergies? _____

4. Do you or have you used hormone replacement therapy? Yes No
 If so, what? _____ When? _____ Dosage? _____

5. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

6. List any significant health issues (diabetes, surgeries, heart disease, etc.)

7. What was the date of your last physical exam? _____

Lifestyle Indicators < = less than > = greater than

1. Do you use any of the following? (circle responses)

Alcohol	None	<2drinks/day	>2 drinks/day
Coffee	None	<2cups/day	>2 cups/day
Soda	None	<2cans/day	>2 cans/day
Sweets/refined carbs		<twice/day	>twice/day
2. Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often? _____
3. How would you rate your stress level? (1= Low, 10= Extreme) 1 2 3 4 5 6 7 8 9 10
4. How would you rate your stress handling? (1= Poor, 10= Excellent) 1 2 3 4 5 6 7 8 9 10
5. How often do you exercise? never rarely sometimes regularly competitively

Male Health History Questionnaire

(continued)

1. Have you had a vasectomy? Yes No When? _____

2. Have you had a reverse vasectomy? Yes No When? _____

3. Have you experienced symptoms related to the vasectomy? Yes No

Explain: _____

4. Do you have a history of prostate problems? Yes No

Explain:

Date of last prostate exam _____

Most recent PSA results _____ Date _____

Sleep Habits

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? _____

2. How many hours do you sleep at night on average? _____

3. Do night sweats wake you up? Yes No How often? _____

4. Do you wake up tired? Yes No How long has this been happening? _____

5. Is your room completely dark when you sleep at night? (*no night light, street lamp, TV, etc.*) Yes No

6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

Male Health History Questionnaire

(continued)

SIGNS & SYMPTOMS	Mild	Moderate	Severe	ADDITIONAL COMMENTS
Low mood / Depression				
Irritability				
Anxiety				
Anger / Aggression				
Discouragement / Pessimism				
Decreased interest in activities/relationships				
Decreased initiative/motivation/drive				
Decreased productivity at work				
Concentration problems				
Memory problems				
Foggy thinking				
Increased fatigue				
Decrease in strength/stamina				
Decrease in athletic performance				
Muscle soreness/weakness				
Body/joint aches				
Weight loss				
Weight gain				
Increased fat on hips/breasts/thighs				
Low blood sugar/hypoglycemia				
Sweet cravings (carbs/chocolate)				
Caffeine/Stimulant cravings				
Salt cravings				
Constant hunger				
Elevated cholesterol				

Male Health History Questionnaire

(continued)

SIGNS & SYMPTOMS	Mild	Moderate	Severe	ADDITIONAL COMMENTS
Elevated blood pressure				
Digestive problems				
Head hair loss				
Body hair loss				
Dry skin/thinning skin				
Decreased spontaneous morning erections				
Lowered libido				
Erectile dysfunction (ED)				
Pain with ejaculation				
Frequent need to urinate				
Urination is delayed/strained/ incomplete				
Pain with urination				
Blood in the urine				
Bone loss/osteoporosis				
Other				