

| **Past Medical History** | **Dates** |
| --- | --- |
| Anemia or history of blood transfusion |  |
| Autoimmune disorder (SLE, Graves, etc.) |  |
| Cancer (describe) |  |
| Candida- Yeast infection- Thrush |  |
| CFS or Fibromyalgia |  |
| Diabetes |  |
| Fatigue (describe, under what conditions) |  |
| Fever or frequent infections |  |
| Generalized weakness |  |
| Heart disease |  |
| Hepatitis |  |
| High blood pressure |  |
| HIV/AIDS |  |
| Hormone imbalance (see page 4) |  |
| Pain/aching |  |
| Where: |  |
| Describe (sharp, dull etc.): |  |
| How long: |  |
| Under what conditions: |  |
| Rheumatic fever |  |
| Seizures |  |
| Swollen glands |  |
| Thyroid disease |  |
| Ooadfnao Other (any hospitalizations): |  |

| **Family Medical History** | **Which Relative** |
| --- | --- |
| Cancer |  |
| Diabetes |  |
| Heart attack or heart disease |  |
| Hepatitis or liver disease |  |
| High Blood Pressure |  |
| HIV/AIDS |  |
| Obesity |  |
| Seizures |  |
| Thyroid disease |  |
| Dementia/Alzheimer’s |  |
| High Cholesterol |  |

| **Personal Habits** |
| --- |
| Smoke packs/day |
| Quit smoking years ago |
| Chew tobacco YES NO |
| Coffee cups/day |
| Tea cups/day |
| Carbonated beverages /day |
| Water cups/day |
| Drink alcohol YES NO |
| If yes: Daily Frequently Occasionally Rarely (circle one) |
| Recreational drugs or marijuana YES NO |
| Alcoholism YES NO |
| Wear nail polish YES NO |
| Wear acrylic nails YES NO |
| Use cosmetics YES NO |
| Get regular exercise YES NO |
| Type: How often: |
| Hours of sleep nightly: |
| How often do you get up at night: |
| Sleep aids: |
| Hours worked per week: |
| What do you do to relax: |
| Spiritually: Do you pray? Meditate? Practice Yoga? Other? |

| **X-Rays, Scans, Endoscopy** | **Dates** |
| --- | --- |
| Abdomen |  |
| Back |  |
| Chest |  |
| Colon |  |
| Extremities |  |
| Full body scan/heart scan |  |
| Gallbladder |  |
| Kidney |  |
| CT scan or MRI of: |  |
| Endoscopy of Colonoscopy |  |

| **Surgeries/Organs removed** | **Dates** |
| --- | --- |
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| **Significant Trauma**  **(Accidents, Falls, Etc.)** | **Dates** |
| --- | --- |
|  |  |
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|  |  |
|  |  |

| **Dental** | **Dates** |
| --- | --- |
| Metal amalgam fillings |  |
| If removed, when: |  |
| TMJ (clenching, grinding) |  |
| Snoring/sleep apnea |  |
| Root canals |  |
| Wisdom teeth extracted |  |
| Crowns/caps |  |
| Metal used: |  |
| Braces/retainer |  |
| Sensitive teeth/sensitive gums |  |
| Dentures |  |
| Last dental cleaning |  |
| Last dental exam |  |
| Last dental images (x-rays) |  |
| Dental problems |  |
| Other: |  |

| **Allergies/Sensitivities** |
| --- |
| Carpet / furniture / cabinets YES NO |
| Chemicals YES NO |
| Cologne smells like bug spray YES NO |
| Cologne, scented products YES NO |
| Dust YES NO |
| Fabric YES NO |
| Food YES NO |
| List: |
| Metals YES NO |
| Mold YES NO |
| Pesticides, fumigation YES NO |
| Pollen YES NO |
| Smoke YES NO |
| Suspect you are allergic but don't know to what YES NO |
| Other allergies YES NO |
| List: |



| **General** |
| --- |
| Cold Feet YES NO |
| Cold hands YES NO |
| Cravings YES NO |
| Excess sleep YES NO |
| Excessive thirst (mouth feels like cotton) YES NO |
| Heavy appetite YES NO |
| Insomnia YES NO |
| Low blood sugar YES NO |
| Peculiar tastes/smells YES NO |
| Poor Appetite YES NO |
| Poor/restless sleep YES NO |

| **Skin & Hair** |
| --- |
| Acne/pimples YES NO |
| Athletes foot YES NO |
| Burning on bottom of feet YES NO |
| Change in skin/hair texture YES NO |
| Changing moles Where: YES NO |
| Crawling sensation YES NO |
| Dry skin YES NO |
| Flushing YES NO |
| Hives YES NO |
| Itching YES NO |
| Oily skin YES NO |
| Rashes YES NO |
| Pale skin YES NO |
| Pigmentation/brown spots YES NO |
| Other: |

| **Eyes, Ears, Nose, Throat** |
| --- |
| Blindness or decreased vision YES NO |
| Bright flashes YES NO |
| Cataracts YES NO |
| Color blindness YES NO |
| Blurred/tunnel vision YES NO |
| Contact lenses YES NO |
| Dark circles under eyes YES NO |
| Eye pain YES NO |
| Eye strain YES NO |
| Floaters in eyes YES NO |
| Glaucoma YES NO |
| Gritty feeling in eyes/dry eyes YES NO |
| Halos around lights YES NO |
| Poor night vision YES NO |
| Sensitive to sunlight or strong light YES NO |
| Swollen, reddened, or sticky eyelids YES NO |
|  |
| Deafness YES NO |
| Drainage from ears YES NO |
| Earaches/ear infections YES NO |
| Hearing aids YES NO |
| Hearing loss YES NO |
| Itching in ear canal YES NO |
| Itching or redness from wearing earrings YES NO |
| Ringing or buzzing in ears YES NO |
|  |
|  |
|  |

| Chills YES NO |
| --- |
| Dizziness (vertigo) YES NO |
| Fatigue YES NO |
| Fevers YES NO |
| Night sweats YES NO |
| Poor heat/cold tolerance YES NO |
| Rarely sweat YES NO |
| Sudden energy drop (time: ) YES NO |
| Sweat easily YES NO |
| Tired upon awakening (feel like you haven’t slept) YES/ NO |
| Other: |

| **Skin & Hair** |
| --- |
| Brittle nails YES NO |
| Bruise easily YES NO |
| Cuts heal slowly YES NO |
| Dandruff YES NO |
| Eczema YES NO |
| Hair Loss YES NO |
| Crown Sides Front Hair line Diffuse sudden |
| Nail fungus YES NO |
| Peeling or cracking of skin on feet YES NO |
| Psoriasis YES NO |
| Split or ridged nails YES NO |
| Sweating YES NO |
| White spots on nails YES NO |
| Other skin/hair problems: |
|  |

| **Eyes, Ears, Nose, Throat** |
| --- |
| Excessive mucous YES NO |
| Nasal polyps YES NO |
| Nose bleeds YES NO |
| Runny nose YES NO |
| Sinus problems YES NO |
| Sneezing attacks YES NO |
| Stuffy nose YES NO |
|  |
| Bleeding gums YES NO |
| Canker sores YES NO |
| Chronic coughing YES NO |
| Cold sores YES NO |
| Cracking around lips/ white tongue YES NO |
|  |
| Frequent sore throats YES NO |
| Enlarged glands YES NO |
| Gagging/frequent need to clear throat YES NO |
| Grinding teeth YES NO |
| Hoarseness YES NO |
| Discoloration of gums YES NO |
| Other gum problems YES NO |
| Swallowing difficulty YES NO |
| Swollen or discolored tongue, gums, or lips YES NO |
| TMJ problems YES NO |
| Tonsillitis YES NO |
| Other: |
|  |
|  |



| **Cardio Vascular** |
| --- |
| Abnormal electrocardiogram (EKG) YES NO |
| Angina (heart / chest pain) YES NO |
| Awaken from sleep with shortness of breath YES NO |
| Blood clots YES NO |
| Coronary Heart Scan (calcium score) YES NO |
| Difficulty breathing YES NO |
| Enlarged heart YES NO |
| Fainting YES NO |
| Heart attack YES NO |
| Heart murmur YES NO |
| Heart surgery YES NO |
| High blood pressure YES NO |
| Holter monitor YES NO |

| **Respiratory** |
| --- |
| Allergies YES NO |
| Asthma YES NO |
| Cough YES NO |
| Coughing blood YES NO |
| Difficulty breathing YES NO |
| Low exercise tolerance YES NO |
| Pain with deep breathing YES NO |
| Shortness of breath with activity or at rest YES NO |
| Sleep apnea YES NO |
| Tuberculosis YES NO |

| **Gastrointestinal** |
| --- |
| Abdominal pain/cramps YES NO |
| Alternating constipation and diarrhea YES NO |
| History of appendicitis YES NO |
| Appetite – poor YES NO |
| Appetite - excessive YES NO |
| Bad breath or bad taste in your mouth YES NO |
| Black or bloody stools YES NO |
| Bloated feeling/ abdominal distention YES NO |
| Bowel habit changes YES NO |
| Colon or bowel trouble YES NO |
| Colon Polyps YES NO |
| Constipation YES NO |
| Crohn’s or ulcerative colitis YES NO |
| Diarrhea, persistent YES NO |
| Diverticulosis or diverticulitis YES NO |
| Frequent blenching/flatulence or gas YES NO |
| Gallbladder attacks or stones YES NO |
| Heliobacter pylori YES NO |
|  |

| **Cardio vascular** |
| --- |
| High cholesterol YES NO |
| Irregular/skipped heartbeats YES NO |
| Low Blood Pressure YES NO |
| Numbness of hands/feet YES NO |
| Pacemaker YES NO |
| Phlebitis YES NO |
| Rapid heartbeats YES NO |
| Swollen hands/feet YES NO |
| Varicose veins YES NO |
| Echocardiogram (heart ultrasound) YES NO |
| Treadmill stress test YES NO |
| Other: |
|  |

| **Respiratory** |
| --- |
| Abnormal chest x-ray YES NO |
| History of bronchietasis YES NO |
| Cystic fibrosis YES NO |
| Chest congestion YES NO |
| COPD or Emphysema YES NO |
| History of Pneumonia YES NO |
| Lung Nodules or calcium deposits YES NO |
| Use inhalers or wheezing YES NO |
| Other: |
|  |

| **Gastrointestinal** |
| --- |
| Hiatial hernia YES NO |
| Heartburn or GERD YES NO |
| Hemorrhoids YES NO |
| Indigestion YES NO |
| Nausea YES NO |
| Nervous stomach YES NO |
| Parasites YES NO |
| Persistent flatulence or gas YES NO |
| Rectal itch or pain YES NO |
| Rectal bleeding YES NO |
| Sensitive abdomen YES NO |
| Sweets upset YES NO |
| Ulcers YES NO |
| Vomiting blood YES NO |
| Bowel movements (how often) per day: |
| Laxative use: per week: type: |
| Other: |
|  |
|  |



| **Genito-Urinary** |
| --- |
| Frequent urination YES NO |
| Interstitial cystitis YES NO |
| Kidney pain (mid back) YES NO |
| Pain on urination YES NO |
| Problem passing urine YES NO |
| Transgender (trans-female or trans-male) YES NO |
| Trouble holding urine/incontinence YES NO |
| Urgency to urinate YES NO |

| **Male reproductive/genitalia** |
| --- |
| Diminished sex desire YES NO |
| Enlarged prostate gland YES NO |
| Erection problems/Impotency YES NO |
| Hernia YES NO |
| Lump in testicles YES NO |
| Night time erections YES NO |
| Penis discharge YES NO |
| Peyroinne’s disease (abnormal curvature of penis) YES NO |

| **Pregnancy & Gynecology** |
| --- |
| Age of first menses (period): |
| Number of pregnancies: Number of births: Miscarriages: |
| Tubal pregnancies: Yes No If Yes, How many: |
| Flow: Heavy / light / clots / (circle one) |
| Period duration: |
| Last mammogram: |
| Last menstrual cycle: |
| Last pap smear: |
| Abnormal pap when: YES NO |
| If so what treatment (repeat pap, cryotherapy/freezing, or medication) |
| Birth control type: |
| Hormone replacement: which? YES NO |
| Menopause (date): YES NO |
| Last pelvic sonogram (ultrasound)? YES NO |
| Breast lumps YES NO |

| **Musculoskeletal** |
| --- |
| Pain: Where: |
| Stiffness: Where: |
| Swelling: Where: |
| Enlarged knuckles or bumps on joints YES NO |
| Where: |
| Head injury YES NO |
| Concussion YES NO |
| Whiplash YES NO |
| Low back stiffness YES NO |
| Loss of consciousness YES NO |
| Mobility problems YES NO |
| Osteoporosis or Osteopenia YES NO |
| Tightness between shoulder blades YES NO |

| **Genito-Urinary** |
| --- |
| Blood in urine YES NO |
| H/O kidney infection YES NO |
| Kidney stones YES NO |
| Sexually transmitted disease YES NO |
| List: |
|  |
| Wake up to urinate: how often /night |
| Other: |

| **Male reproductive/genitalia** |
| --- |
| Premature ejaculation YES NO |
| Sore or lesion on penis YES NO |
| Where: |
|  |
|  |
| Have you tried Viagra, Cialis, or Levitra YES NO |
| Have you tried testosterone YES NO |
| Other: |

| **Pregnancy & Gynecology** |
| --- |
| Low sex drive YES NO |
| Endometriosis YES NO |
| Fibroid Uterus YES NO |
| Hot flashes or night sweats YES NO |
| Infertility, difficulty getting pregnant YES NO |
| Irregular periods YES NO |
| Menstrual cramps or spotting YES NO |
| Nipple discharge or cramps YES NO |
| Pain with intercourse YES NO |
| Pelvic pain YES NO |
| PMS (moody, cravings, breast tenderness, bloating) YES NO |
| Ovarian Cysts or PCOS YES NO |
| Vaginal discharge or itching YES NO |
| Vaginal dryness YES NO |
| Other: |

| **Musculoskeletal** |
| --- |
| Rheumatoid Arthritis YES NO |
| Joint swelling YES NO |
| Muscle weakness, numbness or tingling YES NO |
| Bump on bones YES NO |
| Damp weather causes aching YES NO |
| Body or face not symmetrical YES NO |
| Pain or popping in jaw YES NO |
| Sciatica YES NO |
| Joint pain where: YES NO |
| Joint surgery where: YES NO |
| Do you use a cane? YES NO |
| Other: |
|  |



| **Neuro-psychological** |
| --- |
| Anger, irritability YES NO |
| Anxiety, fear, nervousness (Panic attacks) YES NO |
| Bipolar (elevated & depressed mood, addictions) YES NO |
| Concussions or blunted head trauma YES NO |
| Confusion YES NO |
| Cry often or easily YES NO |
| Depression YES NO |
| Do you want a referral for counseling? YES NO |
| Do you have a family history for mental disorders? YES NO |
| Drug addiction YES NO |
| Easily stressed or overwhelmed YES NO |
| Eating disorder (Anorexia or Bulemia) YES NO |
| Schizophrenia YES NO |
| Fatigue or sluggishness YES NO |
| Feel inferior YES NO |
| Feel like life is demanding/stressful YES NO |
| Feel like life is unsatisfactory YES NO |
| Friends tell you that you drink too much YES NO |
| Hair loss YES NO |
| Have you been hospitalized for depression YES NO |
| Headaches(stress, tension, migraines, cluster) YES NO |
| Where? Front Back Sides when? |
| History of seizures YES NO |
| Hyperactivity or ADD YES NO |
| Insomnia (cant go to sleep or awaken from sleep) YES NO |

| **Medical Problems Not Covered Elsewhere** |
| --- |
| Recurrent skin infections YES NO |
| Broken bones YES NO |
| Cirrhosis or liver disease YES NO |
| Gout YES NO |
| Goiter (enlarged thyroid) YES NO |
| Mononucleosis YES NO |
| Drug reaction YES NO |
| Biopsies YES NO |

| **Electromagnetic Radiation** |
| --- |
| Frequent x-rays YES NO |
| Live under or around power lines YES NO |
| Use a cellular or portable phone YES NO |
| Do you use an ear piece for your cell phone YES NO |

| **Birth Factors –“were you…”** |
| --- |
| Birth trauma (describe) |
| Bottle fed YES NO |
| Breast fed YES NO |
| Adopted YES NO |

| **Neuro-psychological** |
| --- |
| Alzheimer’s or Parkinson’s YES NO |
| Areas of numbness or tingling YES NO |
| Where: |
| Have you ever considered or attempted suicide YES NO |
| Are you suicidal now YES NO |
| Have you seen a counselor or psychiatrist YES NO |
| Multiple personality disorder YES NO |
| Mood swings YES NO |
| Slurred speech YES NO |
| Sense of despair or socially isolated YES NO |
| Stuttering, stammering YES NO |
| Learning disabilities (dyslexia) YES NO |
| Leg or arm weakness YES NO |
| Have you taken meds for anxiety or depression YES NO |
| Phobias, irrational fears YES NO |
| Poor concentration or coordination YES NO |
| Strokes (mini-stroke or TIA) YES NO |
| Poor memory or forgetfulness YES NO |
| Restlessness YES NO |
| Treatment for emotional problems YES NO |
| Tremors (shaking, twitching) YES NO |
| Worry frequently YES NO |
| Startled at night, nightmares, or vivid dreams YES NO |
| Nervous breakdown YES NO |
| Other: |

| **Medical Problems Not Covered Elsewhere** |
| --- |
| Obesity YES NO |
| Parasites YES NO |
| Abnormal blood clotting YES NO |
| Polio YES NO |
| Rheumatic fever YES NO |
| Slow metabolism YES NO |
| Warts YES NO |
| Other: |

| **Electromagnetic Radiation** |
| --- |
| Use a water bed or electric blanket YES NO |
| Work with computers YES NO |
| Other radiation exposure YES NO |
| Describe: |

| **Birth Factors –“were you…”** |
| --- |
| Is medical info available from birth parents YES NO |
| Casarean section or forceps delivery YES NO |
| Premature YES NO |
| Unknown YES NO |



Risk of Exposure

| Circle the corresponding number for Questions A-E Below | |
| --- | --- |
| (0) Never (1) Rarely (2) Monthly (3) Weekly (4) Daily | |
|  | |
| a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) | 0 1 2 3 4 |
| b. How often are pesticides used in your home? | 0 1 2 3 4 |
| c. How often do you have your home treated for insects? | 0 1 2 3 4 |
| d. How often are you exposed to nail polish, perfume, hair spray, and other cosmetics? | 0 1 2 3 4 |
| e. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? | 0 1 2 3 4 |
|  | |
|  | |
| Circle the corresponding number for the questions below | |
| (0) No (1) Mild Change (2) Moderate Change (3)Drastic Change | |
|  | |
| Have you noticed any negative change in your health since you moved into your home or apartment? | 0 1 2 3 |
| Have you noticed any negative change in your health since you started your new job? | 0 1 2 3 |
|  | |
|  | |
| Do you have a water purification system in your home? | YES NO |
| Do you have any indoor pets? | YES NO |
| Do you have an air purification system in your home? | YES NO |
| Are you a dentist, painter, farm worker, or construction worker? | YES NO |
|  | |
| **Describe your work history. Include exposure to chemicals, fumes, pesticides, metals, heavy lifting, electromagnetic fields, radiation, asbestos, high stress, and anything that may be health related.** | |
| Dates: Description of work: | |
|  | |
|  | |
| Dates: Description of work: | |
|  | |
|  | |
| **Briefly describe where you have lived since childhood – part of country/world, in city/rural, etc., and potential exposures from ill patient, unusual neighbors’ occupations (cattle rearing, farming, raising pigeons or turtles) etc** | |
|  | |
|  | |
|  | |
|  | |
| **Describe your hobbies, sports, and forms of recreation, with attention to exposure as listed under work history** | |
|  | |
|  | |
|  | |
| **Are you interested in a weight program?** | |
| **What diets or weight loss programs have you tried and were you successful?** | |
|  | |
|  | |
|  | |
|  | |
| **Is there anything else you would like to let us know?** | |
|  | |
| **What is your biggest concern that you would like to discuss today?** | |
|  | |
|  | |
|  | |
|  | |
|  | |

Circle the corresponding number for the items below

1. –No or Never
2. –Yes or Sometimes
3. –Often

| **Nutritional** | | | | |
| --- | --- | --- | --- | --- |
| Abnormal thirst | 0 1 2 |  | Age spots | 0 1 2 |
| Avoid cruciferous vegetables | 0 1 2 | Avoid exercise | 0 1 2 |
| (e.g. cauliflower, brussel sprouts, asparagus) | | Bulemia (binge / purge) |  |
| Avoid red fruits or vegetables | 0 1 2 | Cholesterol above 200 | 0 1 2 |
| (e.g. tomatoes, cranberries, cherries) | | Difficulty gaining or maintaining weight |  |
| Bad breath | 0 1 2 | Difficulty losing weight even on a diet | 0 1 2 |
| Appetite loss, anorexia | 0 1 2 | Difficulty strengthening muscles | 0 1 2 |
| Consume commercially produced dairy products | 0 1 2 | Drink chlorinated water | 0 1 2 |
| Consume hydrogen fats | 0 1 2 | Drink non-filtered water | 0 1 2 |
| Craving for alcohol | 0 1 2 | Drink sweet beverages | 0 1 2 |
| Raving for bread, starches, or pasta | 0 1 2 | Eat candy or sweets | 0 1 2 |
| Cravings for coffee, tea, cola | 0 1 2 | Eat fatty food | 0 1 2 |
| Cravings for fatty foods | 0 1 2 | Eat food that is not organically grown | 0 1 2 |
| Cravings for salt | 0 1 2 | Eat less than 4 servings of grain a day | 0 1 2 |
| Cravings for spicy foods | 0 1 2 | Eat less than 3 servings of fresh fruit a day | 0 1 2 |
| Cravings for sweets, fruit | 0 1 2 | Eat less than 2 servings of dairy products a day | 0 1 2 |
| Cravings for vinegar, ketchup | 0 1 2 | Eat less than 2 servings of fresh, dark-colored, vegetables a day | 0 1 2 |
| Other cravings—type? | 0 1 2 | Eat more thank 6 oz of protein a day | 0 1 2 |
| Distress eating fatty foods | 0 1 2 | Eat white bread | 0 1 2 |
| Drink carbonated beverages | 0 1 2 | Excessive fatigue during workouts | 0 1 2 |
| Drink fluoridated water | 0 1 2 | Eat meat (vegetarian or vegan) | 0 1 2 |
| Eat commercially raised meat | 0 1 2 | Excessive wrinkling of the skin/premature aging | 0 1 2 |
| Eat cooked and/or processed food | 0 1 2 | Food allergy, proven or suspected | 0 1 2 |
| Eat rapidly, without chewing thoroughly | 0 1 2 | Graying of the hair | 0 1 2 |
| Eat until you feel full | 0 1 2 | Have a small appetite | 0 1 2 |
| Emotional or stress eater | 0 1 2 | Have stress in your life | 0 1 2 |
| Feel a need to eliminate too soon after eating | 0 1 2 | High fat diet | 0 1 2 |
| Feel flush after eating | 0 1 2 | Hungry soon after meal | 0 1 2 |
| Feel sleepy or have low energy after eating | 0 1 2 | Hyperactivity or excessive nervousness without food | 0 1 2 |
| Feel too full after eating | 0 1 2 | Muscles feel weak after performing daily activities | 0 1 2 |
| Food passes through undigested | 0 1 2 | Persistent cramps | 0 1 2 |
| Foreign travel in the last 90 days | 0 1 2 | Poor smell / taste | 0 1 2 |
| Get indigestion after eating | 0 1 2 | Pulse speeds after meals | 0 1 2 |
| Have diarrhea after eating | 0 1 2 | Sleepy after meals | 0 1 2 |
| Have difficulty breathing after eating | 0 1 2 | Take vitamins | 0 1 2 |
| Have uncomfortable or adverse reactions after eating | 0 1 2 | Trouble sleeping | 0 1 2 |
| History of food poisoning | 0 1 2 | Unpleasant taste in mouth | 0 1 2 |
| Low carbohydrate diet | 0 1 2 | Weakness or faintness between meals | 0 1 2 |
| Low energy | 0 1 2 | Weight gain | 0 1 2 |
| Low fiber diet | 0 1 2 | Weight loss | 0 1 2 |
| Undergone surgery in the last 90 days | 0 1 2 | Would you like to work with our nutritionist | 0 1 2 |
| Practice mindful eating  (No distractions, e.g. TV or work) | 0 1 2 | Other | |
| Read nutritional labels | 0 1 2 |

Physician Notes:

Physician Signature: Date: