Information for the Physician

Date:

Name:

1. All medications, vitamins and health care preparations you are using for any reason.

Medication	Dosage	When and How Used
______________________	_____________	_______________________________
______________________	_____________	_______________________________
______________________	_____________	_______________________________
______________________	_____________	_______________________________
______________________	_____________	_______________________________

2. A medical history of you and your family:

Your history

____

____

____

Mother's side of the Family

____

____

Father's side of the Family

____

____

3. Describe changes in:

appetite or diet ____

____

weight ____

sleep patterns ____

____

sexual interest ____

ability to concentrate ____

memory ____

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Information for the Physician [con't]

Name:

Have you recently had:

____ headaches (describe)

____

____ numbness or tingling anywhere (where?)

____

_____ loss of balance (describe)

____

____ double vision or vision problems (describe)

____

____ periods of amnesia (describe)

____

____ coordination changes (describe)

____

____ weakness in arms or legs (describe)

____

____ fever (describe)

____

____ nausea or diarrhea (describe)

____

____ other gastrointestinal problems (describe)

____

____ fainting or dizziness (describe)

____

____ seizures (describe)

____

____ stressful life events (describe)

____

Add additional sheets for other pertinent information.

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