

377 Macktown Road Sylva, NC 28779 Office: (828)586-6262 Fax: (828)412-4294

Welcome

Dogwood Wellness is moving into the new frontier called **integrative medicine.** What this means for you is better and more personalized care.

We help you move toward complete wellness by helping you discover and understand the hidden causes of your health challenges… and create a customized and comprehensive treatment plan for you.

Our goal is to educate you and create an awareness that allows you to make smart and natural health choices toward improving your health and wellbeing. This is not just a one-time goal but rather a lifelong mission for you as well as the rest of us. Most people will agree that their health is their own responsibility but fall short when it comes to translating that responsibility to their daily activities. The way our medical care is delivered is partially at fault. Dogwood Wellness is one of many systems around the country who are changing the way medical care is delivered. Our team spends time with you, listening to your history, and looking at ways that your genetic makeup, environment, and lifestyle factors have influenced your health. This is called integrative medicine. Integrative medicine, by definition, integrates traditional Western medical practice with other modalities. We use laboratory testing as well as other appropriate diagnostic techniques and then will prescribe combinations of therapeutic diets, exercise, drugs, botanicals, supplements, detoxification programs, stress management or whatever you need to obtain and maintain your optimum level of wellness.

We believe that a good life is your greatest possible resource and needs to be managed-not by drugs but by improved life style-good dietary habits, appropriate exercise and stress reduction. It is a choice to be made-not by us but by you. We are here to assist you in this journey. We will not dictate our wishes but will express them only as guide lines. It is ultimately your decision how that journey will look.

We ask that you be an active partner and be willing to learn about those areas in your life that are not serving you well. We may teach you something, but ultimately it is your decision whether or not to institute these new ideas.

Just as financial planning or family planning is important, health care planning is just as important and, maybe, even more important than anything else you do. Your body is a wonderful machine and can heal itself when given the “tools” it needs to do the job. Rather than rely on technology and drugs, your body can heal itself using various complementary modalities such as proper supplementation, acupuncture, chiropractic care, Tai Chi as well as diet, exercise, and learning stress reduction methods. Health care is proactive and takes time and effort. It may even take resources you feel you do not have but, while on this journey, you will feel better, feel empowered, and will be better able to handle what comes your way.

We look forward to working with you.



377 Macktown Road Sylva, NC 28779 Office: (828)586-6262 Fax: (828)412-4294

TO: All Dogwood Wellness Patients

RE: No call/no show for scheduled appointments

**ALL CANCELLED APPOINTMENTS NEED AT LEAST 24 HOUR NOTICE!!!**

If you fail to keep your appointment for whatever reason, it will be **1 month** before your next appointment will be scheduled.

Also, if you are a no call/no show then there will be a **$25.00 charge** on your account which **must** be paid before being seen again.

*\*NOTE: If your scheduled appointment is on a Monday then you need to call us by 2pm on Friday to cancel the appointment.*

If this was a scheduling error, a duplicate appointment or if there was an important reason that you would like to share with us, please do not hesitate to call and let us know.

Your health is important to us; however, we cannot help take care of you if you do not keep your appointments. Each appointment you miss is a time when another patient who needs an appointment could have been scheduled.

**(828) 586-6262 Office (828) 412-4294 Fax**

**After Hours: (828) 506-0904 text or call**

We appreciate your understanding,

*Dogwood Wellness*

**DOGWOOD WELLNESS, PA**

**Patient Information**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

911 Addresses (If PO BOX):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: F / M

E-mail Address (for Patient Portal Access): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_

***Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Relationship to Patient: Spouse Significant Other Parent Guardian Sibling***

***Mailing Address (IF different from patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_***

***May this person have access to all of your information? YES / NO***

**Insurance Information:** Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Issue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Responsible for Payment:** Self Spouse Significant Other Parent Guardian Other

***Please complete the following if this is someone other than the patient, otherwise you may leave blank.***

Policy/Card Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOGWOOD WELLNESS, PA**

DOGWOOD WELLNESS HEALTH PRIVACY NOTICE

I acknowledge that I have read Dogwood Wellness Notice of Privacy Practices and have been given the opportunity to request a copy.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your privacy is important to us. Your ability to access your own health information is also important. We have a patient portal, and much of your information will be available there. Other ways to access your information or to be contacted are below.

**Please initial your preferences.**

The above named practice is authorized to disclose protected health information to those I have checked below:

\_\_\_ Voicemail or answering machine: OK to leave information. Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ E-mail or text message: OK to send appointment reminders. Remember that we cannot send protected health information via e- mail or text. You can sign into the portal.

\_\_\_ Spouse/significant other/parent/other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to discuss health information with them.

\_\_\_ Do not give information to anyone except myself

Some patients do not use us as a primary care provider. If you are one of those individuals, please list your current primary care provider below.

The above named practice is authorized to disclose protected health information to my Primary Care Provider

Primary Care Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOGWOOD WELLNESS FINANCIAL POLICY

**Your health is very important to us.**

**Co-pays, Co-insurance, deductibles are due at the time of service.**

**If you cannot pay your bill in full, please let us know so we can work with you to make a payment arrangement.**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DOGWOOD WELLNESS AND/OR SURGICAL BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED CHARGES MADE FOR SUCH TREATMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES **NOT** COVERED BY MY INSURANCE.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I HEREBY AUTHORIZE DOGWOOD WELLNESS TO RELEASE TO MY INSURANCE COMPANY (or pending insurance company) ANY INFORMATION REQUIRED, INCLUDING THE DIAGNOSIS AND RECORDS PRODUCED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I acknowledge a $25 fee will be charged if I do not provide a 24 hour notice for cancellation and/or no-show appointment. I understand this policy is strictly enforced by Dogwood Wellness, PA.**

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Symptoms Questionnaire**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for:

**Circle which one below:**

***Past 30 days OR Past 48 hours***

Point Scale: **0 – *Never* or almost *never* have the symptom**

**1 – *Occasionally* have it, effect is *not severe***

**2 – *Occasionally* have it, effect is *severe***

**3 – *Frequently* have it, effect is *not severe***

**4 – *Frequently* have it, effect is *severe***

**(Put Corresponding number next to symptom)**

HEAD \_\_\_\_ Headaches

\_\_\_\_ Faintness

\_\_\_\_ Dizziness

\_\_\_\_ Insomnia Total\_\_\_\_

EYES \_\_\_\_ Watery or itchy eyes

\_\_\_\_ Swollen, reddened or sticky eyelids

\_\_\_\_ Bags or dark circles under eyes

\_\_\_\_ Blurred or tunnel vision

(does not include near or far-sightedness) Total\_\_\_\_

EARS \_\_\_\_ Itchy ears

\_\_\_\_ Earaches, ear infections

\_\_\_\_ Drainage from ear

\_\_\_\_ Ringing in ears, hearing loss Total\_\_\_\_

NOSE \_\_\_\_ Stuffy nose

\_\_\_\_ Sinus problems

\_\_\_\_ Hay Fever

\_\_\_\_ Sneezing Attacks

\_\_\_\_ Excessive mucus formation Total\_\_\_\_

MOUTH/THROAT \_\_\_\_ Chronic coughing

\_\_\_\_ Gagging, frequent need to clear throat

\_\_\_\_ Sore throat, hoarseness, loss of voice

\_\_\_\_ Swollen or discolored tongue, gums, lips

\_\_\_\_ Canker Sores Total\_\_\_\_

SKIN \_\_\_\_ Acne

\_\_\_\_ Hives, rashes dry skin

\_\_\_\_ Hair loss

\_\_\_\_ Flushing, hot flashes

\_\_\_\_ Excessive sweating Total\_\_\_\_

HEART \_\_\_\_ Irregular or skipped heartbeat

\_\_\_\_ Rapid or pounding heartbeat

\_\_\_\_ Chest pain Total\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LUNGS \_\_\_\_ Chest congestion

\_\_\_\_ Asthma, bronchitis

\_\_\_\_ Shortness of breath

\_\_\_\_ Difficulty breathing Total\_\_\_\_

DIGESTIVE TRACT \_\_\_\_ Nausea, vomiting

\_\_\_\_ Diarrhea

\_\_\_\_ Constipation

\_\_\_\_ Bloating feeling

\_\_\_\_ Belching, passing gas

\_\_\_\_ Heartburn

\_\_\_\_ Intestinal/stomach pain Total\_\_\_\_

JOINTS/MUSCLE \_\_\_\_ Pain or aches in joints

\_\_\_\_ Arthritis

\_\_\_\_ Stiffness or limitation of movement

\_\_\_\_ Pain or aches in muscles

\_\_\_\_ Feeling of weakness or tiredness Total\_\_\_\_

WEIGHT \_\_\_\_ Binge eating/drinking

\_\_\_\_ Craving certain foods

\_\_\_\_ Excessive weight

\_\_\_\_ Compulsive eating

\_\_\_\_ Water retention

\_\_\_\_ Underweight Total\_\_\_\_

ENERGY/ACTIVITY \_\_\_\_ Fatigue, sluggishness

\_\_\_\_ Apathy, lethargy

\_\_\_\_ Hyperactivity

\_\_\_\_ Restlessness Total\_\_\_\_

MIND \_\_\_\_ Poor memory

\_\_\_\_ Confusion, poor comprehension

\_\_\_\_ Poor concentration

\_\_\_\_ Poor physical coordination

\_\_\_\_ Difficulty in making decisions

\_\_\_\_ Stuttering or stammering

\_\_\_\_ Slurred speech

\_\_\_\_ Learning disabilities Total\_\_\_\_

EMOTIONS \_\_\_\_ Mood swings

\_\_\_\_ Anxiety, fear, nervousness

\_\_\_\_ Anger, irritability, aggressiveness

\_\_\_\_ Depression Total\_\_\_\_

OTHER \_\_\_\_ Frequent illness

\_\_\_\_ Frequent or urgent urination

\_\_\_\_ Genital itch or discharge Total\_\_\_\_

**GRAND TOTAL *TOTAL \_\_\_\_\_\_\_\_\_***

**DOGWOOD WELLNESS**

**ADULT MEDICAL QUESTIONNAIRE**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With Whom Do You Live? (Please Include Children, Parents, Relatives, Friends, and Include Ages)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by or how did you hear about us?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List Your Current Problems. Please Rate them (mild moderate, severe). Provide the Treatment Approach and How Successful the Treatments are. (Example: Hip Pain-Moderate-Physical Therapy-Pain Medication-Limited Help)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Medications (Prescriptions and OTC) are you taking now?

NAME: DOSAGE: MEDICAL PROBLEM:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List All the Supplements, the Brand and Dosage that You are Taking Now.

NAME: DOSAGE: WHY TAKING?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you Allergic to Any Medications? YES: \_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_

If YES, then Which One’s and Please List Reactions:

NAME: REACTION:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please List Dates Following the Vaccinations If You Have Received Them:

Influenza: \_\_\_\_\_\_\_\_\_\_ BC: \_\_\_\_\_\_\_\_\_ Pneumonia: \_\_\_\_\_\_\_\_\_\_

Varicella: \_\_\_\_\_\_\_\_\_ Tetanus: \_\_\_\_\_\_\_\_\_ Gardasil: \_\_\_\_\_\_\_\_\_\_

**DOGWOOD WELLNESS, PA**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you EVER had the following exams? If so, please tell us why and the results of the exam. (Please Circle)

Prostate Biopsy YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thermogram YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Esophageal Endoscopy YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiogram (EKG) YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiac Stress Test YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ECHO YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest X-Ray YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cat Scan YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulmonary Function Test YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EEG (brain waves) YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Density Test YES NO Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List ALL the Surgeries You Have Had and the Dates of Procedure.

PROCEDURE: DATE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age You Became Sexually Active: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Lifetime Sexual Partners: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any of the following you have been treated for in the past:

Chlamydia Gonorrhea Herpes Genital Warts Trichomonas HIV

**DOGWOOD WELLNESS, PA**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MALE PATIENTS SKIP TO NEXT PAGE***

***FEMALE PATIENTS CONTINUE BELOW:***

Date of Pap Last Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatments Required for Abnormal Pap Smears: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of First Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal History of Any of the Following: Heavy Periods: \_\_\_\_\_\_\_\_\_ Painful Periods: \_\_\_\_\_\_\_\_\_

Irregular Periods: \_\_\_\_\_\_\_\_\_ Skipping Periods: \_\_\_\_\_\_\_\_\_ Painful Intercourse: \_\_\_\_\_\_\_\_\_

Bleeding After Intercourse: \_\_\_\_\_\_\_\_\_ Infertility: \_\_\_\_\_\_\_\_\_

Are you currently using any type of contraception? YES: \_\_\_\_\_ NO: \_\_\_\_\_

If so what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in Menopause? YES: \_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_

If Yes, Age of Last Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of menopause: \_\_\_\_\_\_\_\_\_\_\_\_ Any Bleeding After Menopause? YES: \_\_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take Hormone Replacements? YES: \_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_

How Long have You been on Hormone Replacement Therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Pregnancies: \_\_\_\_\_\_\_ \_\_\_\_\_ Total Living Children: \_\_\_\_\_\_\_\_\_\_\_\_

Still Birth: \_\_\_\_\_\_\_ Miscarriage: \_\_\_\_\_\_\_ Abortions: \_\_\_\_\_\_\_\_ C-Sections: \_\_\_\_\_\_\_

Delivery Date Weeks Pregnant Gender Weight

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery Date Weeks Pregnant Gender Weight

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery Date Weeks Pregnant Gender Weight

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Delivery Date Weeks Pregnant Gender Weight

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Delivery Date Weeks Pregnant Gender Weight

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOGWOOD WELLNESS, PA**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:**

**Please check whether you as the patient under (P) or under (F) for family put the corresponding letter of the relative that had the medical condition as follows:**

**(M) Mother, (F) Father, (S) Sibling, (MGM) Maternal Grandmother, (MGF) Maternal Grandfather,**

**(PGM) Paternal Grandmother, (PGF) Paternal Grandfather.**

**P F**

\_\_\_ \_\_\_ Adrenal Dysfunction

\_\_\_ \_\_\_ Alzheimer

\_\_\_ \_\_\_ Amyotrophic Lateral Sclerosis

\_\_\_ \_\_\_Anemia

\_\_\_ \_\_\_ Angina

\_\_\_ \_\_\_Anorexia or Bulimia

\_\_\_ \_\_\_ Anxiety Disorder

\_\_\_ \_\_\_AV Malformations

\_\_\_ \_\_\_ Arthritis

\_\_\_ \_\_\_Asthma

\_\_\_ \_\_\_ Autoimmune Disease

\_\_\_ \_\_\_Bipolar Disorder

\_\_\_ \_\_\_ Bleeding Disorder

\_\_\_ \_\_\_Bronchitis

\_\_\_ \_\_\_ Cataracts

\_\_\_ \_\_\_**Stroke**

\_\_\_ \_\_\_ Chemotherapy

\_\_\_ \_\_\_**Cancer**

\_\_\_ \_\_\_ Claudication

\_\_\_ \_\_\_Clotting Disorder

\_\_\_ \_\_\_ Congenital Heart Defects

\_\_\_ \_\_\_Coronary Heart Disease

\_\_\_ \_\_\_ COPD or Emphysema

\_\_\_ \_\_\_Crohns Disease

\_\_\_ \_\_\_ Chronic Fatigue Syndrome

\_\_\_ \_\_\_Cystic Fibrosis

\_\_\_ \_\_\_ Depression

\_\_\_ \_\_\_**Diabetes**

\_\_\_ \_\_\_ Dialysis

\_\_\_ \_\_\_Eclampsia or Pre-Eclampsia

\_\_\_ \_\_\_ Endocarditis

\_\_\_ \_\_\_Endometriosis

\_\_\_ \_\_\_ Erectile Dysfunction

\_\_\_ \_\_\_Fibromyalgia

\_\_\_ \_\_\_ Gallstones

\_\_\_ \_\_\_Gastritis or Gastric Ulcer

\_\_\_ \_\_\_ GERD (Reflux)

\_\_\_ \_\_\_Esophageal Dysfunction

\_\_\_ \_\_\_ Glaucoma

\_\_\_ \_\_\_Gout

\_\_\_ \_\_\_ Heart or Valve Defects

\_\_\_ \_\_\_**Heart Attack**

\_\_\_ \_\_\_ Hemochromatosis

\_\_\_ \_\_\_High Blood Fats

**P F**

\_\_\_ \_\_\_ Hepatitis

\_\_\_ \_\_\_HIV or AIDS

\_\_\_ \_\_\_ **Hypertension** (high blood pressure)

\_\_\_ \_\_\_Hyperthyroidism

\_\_\_ \_\_\_ Irritable Bowel

\_\_\_ \_\_\_Inflammatory Bowel Disease (IBS)

\_\_\_ \_\_\_ Kyphosis

\_\_\_ \_\_\_Liver Dysfunction

\_\_\_ \_\_\_ Kidney Failure or Dysfunction

\_\_\_ \_\_\_ Mania

\_\_\_ \_\_\_Mononucleosis

\_\_\_ \_\_\_ Muscular Dystrophy

\_\_\_ \_\_\_Narcolepsy

\_\_\_ \_\_\_ Obstructive Sleep Apnea

\_\_\_ \_\_\_Organ Transplant

\_\_\_ \_\_\_ **Osteoporosis**

\_\_\_ \_\_\_Osteopenia

\_\_\_ \_\_\_ Pancreatitis

\_\_\_ \_\_\_Peripheral Artery Disease

\_\_\_ \_\_\_ Personality Disorder

\_\_\_ \_\_\_Pituitary Dysfunction

\_\_\_ \_\_\_ Polycystic Ovarian Syndrome

\_\_\_ \_\_\_Pneumonia

\_\_\_ \_\_\_ Pulmonary Artery Hypertension

\_\_\_ \_\_\_Pulmonary Fibrosis

\_\_\_ \_\_\_ Radiation Therapy

\_\_\_ \_\_\_Recurrent Infections

\_\_\_ \_\_\_ Restless Leg Syndrome

\_\_\_ \_\_\_Rheumatic Fever

\_\_\_ \_\_\_ Sarcoidosis

\_\_\_ \_\_\_Schizophrenia

\_\_\_ \_\_\_ Scoliosis

\_\_\_ \_\_\_Scleroderma

\_\_\_ \_\_\_ Seizure Disorder

\_\_\_ \_\_\_Sickle Cell

\_\_\_ \_\_\_ Sjogren

\_\_\_ \_\_\_Sinus Problems

\_\_\_ \_\_\_ Skin Disorder

\_\_\_ \_\_\_Thalassemia

\_\_\_ \_\_\_ Thyroid Problems

\_\_\_ \_\_\_Thrombocytopenia

\_\_\_ \_\_\_ Thrombophilia

\_\_\_ \_\_\_Transfusions

\_\_\_ \_\_\_ Tuberculosis

\_\_\_ \_\_\_Ulcerative Colitis

\_\_\_ \_\_\_ Urinary Retention or Urgency

\_\_\_ \_\_\_Urinary Incontinence

\_\_\_ \_\_\_ Vocal Cord Dysfunction Paralysis

**DOGWOOD WELLNESS, PA**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB::\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY

Please check appropriate space(s) for mother with an “M” and father with an “F” and yourself with an “S”.

Nationality for Family.

African American Hispanic Mediterranean Asian

Caucasian Northern European Native American

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Smoke? YES: \_\_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_

How much do you smoke? (# of cigarettes/packs )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever quit? YES: \_\_\_\_\_ NO: \_\_\_\_\_

Why did you start smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to second hand smoke on a regular basis? YES: \_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_

Describe how your health will change if you do quit smoking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Consume Alcoholic Beverages? YES: \_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_

If YES, How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You Ever Used IV Drugs? YES: \_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_

If YES, How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_