Hello and thank you for your interest in a risk assessment by Dr Wischmeyer using the Bale-Doneen-Method.

The goal of this program is to determine your risk or 'level' for heart attack and stroke and if risk is found to determine why you are at risk and how to reverse or lower your risk level. The end goal is to keep your arteries 'cool '(not inflamed) and healthy. This process will probably take about 8-10 weeks. We do have a few clients in front of you at this point. I will send new patient forms to be completed if you decide you are interested. When I get these forms returned the process will begin

What is needed: I will assist you every step of the way!!!

1. Medical records and dental records last 2 years. If there are any heart issues, all records need to be requested for this health issue.
2. Current labs: It takes about 3 hours to get to the labs drawn at Quest. Labs will be done at Quest and Cleveland Heart. The cash option is the very best way to go. Genetics are not covered under insurance plans and can be as much as $2000.00 each. We do 4-5 genetics tests. Paying cash, Quest charges about 800$ Once labs are drawn it takes about 2 weeks to get results, and we will set appointments then.
3. Oral DNA and 3 D CT scan of your mouth (done at dentist) Cost generally under $600.00
4. Calcium Score and EKG done at Lubbock Heart Hospital. LHH will discuss charges with you. Calcium score is a cash cost also; approximately $150.00 Insurance does not cover calcium score. EKG's costs depend on insurance.
5. C-IMT scan This is a quick noninvasive ultrasound of your neck arteries. Cost $350.00 (availability of this service is about 3 times a year)
6. Dr Wischmeyer's initial fee is $3000.00. Dr Wischmeyer does not bill his professional time to insurance companies. No credit card is available. A detailed invoice will be given. This invoice can be used for a health savings account.

Your first risk access visit is generally broken up into 2 visits. The first visit is 1-2 hours long to review family and personal history and do a brief physical examination.

The second visit is where you will receive the lab and studies review. A personalized plan will be developed for you. A discussion of long-term care will be discussed at this visit if deemed necessary.

**** Visits may be combined depending on schedules for all involved.

Should you be a candidate for the long-term program that is an additional cost of $3300.00 per year. The frequency of visits for that year is usually no more than 4 but can be less or more depending on your health. The annual fee does include access to a nurse and Dr Wischmeyer as needed during the year. When you come in, you will have quality time and not be on a treadmill schedule as regular, standard of care office practices require.

In the long-term program, we will get necessary labs and review results, sometime in person or sometimes on the phone to keep you safe from events!

Dr Wishmeyer risk assessment or annual fee does not include labs or other studies. These fees are strictly professional fees. You are encouraged to use your insurance for labs and studies.

Below in an attachment, are the necessary forms to start the process. Please print these forms complete and CALL ME ANYTIME call. This process is challenging but well worth it!!

We strongly believe heart attacks and ischemic strokes are preventable and with proper management and follow-up one can live a full life without these life changing events.

Look forward to working with you!

Judy V. Stalcup RN BSN
Arteriology Nurse
Lubbock, TX 806-535-1388

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Authorization to Disclose Information

I hereby authorize the use of information from the medical record of:

Name: _____ Date: _____

Date of Birth: _____ Social Security: _____

I authorize the following individuals or organization to disclose the above-named individual health information:

Name: _____ Address: _____

This Information may be disclosed to and used by the following individual or organization:

Jason Wischmeyer, MD PhD FACC PA

3413 20th Street - Lubbock, TX 79410 – FAX: 806-701-2560

For the purpose of: Medical Treatment

Please release the following:

Problem List	List Allergies	x-ray/imaging reports
Progress Notes	x-ray films	Genetic Testing Information
History and Physical Exam	Laboratory result	Other Diagnosis reports
Medication List	EKG reports	Other

I understand that the information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behaviors or mental services, and treatments for alcohol and drug abuse.

[ ] YES, I consent to the release of this information. [ ] NO, I do not consent to the release of this information.

I understand that I have the right to revoke this authorization anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing this disclosure or this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosures the information may not be protected by the federal confidentiality rules.

_____

Signature of Patient or Legal Representative Date

_____

Relation to Patient (If Legal Representative) Date

Complete only if information is to be released directly to patient	
Signature of Patient or Legal Representative	Date
Relation to Patient (if Legal Representative)	Witness

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Doctor's Information Form

Your Name: _____ D.O.B:_____

1. Primary Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

2. Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

3. Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

4. Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

5. Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

Please make sure to provide all information needed. If you have more Physicians, please finish on the back side of this sheet. You only need to list Physicians you have seen within the last 3-5 years.

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Dear Very Important Patient,

Thank you for your interest in our cardiovascular disease prevention program. Attention to your vascular health at this time in your life will have many lasting benefits. As you probably know, heart attacks are the number one killer in this country and about 60% of those who suffer a heart attack had no idea they had a problem. Strokes are the third largest killer and the biggest cause of disability; and again, often strike without warning. In addition, the prevalence of diabetes, this country's most expensive disease, continues to rise. The debilitating effect of heart attacks, strokes, and diabetes, not to mention the socioeconomic impact on our society, touches all of our lives.

It is important to identify who is at risk as proven therapies are now available which can alter the natural progression of arterial disease. In many cases these therapies can prevent or delay the onset of disease. At this clinic, I specialize in identifying those at risk and developing an individualized treatment plan including proper lifestyles advice and/or medications. With a comprehensive aggressive approach, regression of disease can occur making this approach an asset to those with current disease, as well as those who do not have known disease but are at risk from these silent killers.

It is important to note that this is a specialty clinic devoted strictly to the prevention of heart attacks, strokes, and diabetes. I am not a replacement for your current health care provider, but an asset to your prevention efforts to live a healthy life. My goal is to perform a comprehensive individual assessment looking at all aspects of your health profile as it relates to your vascular health. A treatment plan is formulated incorporating the Bale/Doneen Method along with a specific in-depth educational approach.

I look forward to working with you to ensure that you receive the necessary screening and treatment required to meet your healthcare goals and achieve optimum vascular health.

Sincerely,

Jason B. Wischmeyer, M.D, PhD, FACC, PA

3413 20th Street • Lubbock, TX 79410 • PH: 806.535.1388 • FAX: 806.701.2560 • optimalhearthealth.com

Appointment information:

Before the First Office Visit: Before your first appointment it is essential that all of your medical records be sent to our office. To do this, please complete the attached Medical Records Release / Consent form. Make enough copies to give one to each of your medical providers requesting that they send copies of your records to:

Jason B. Wischmeyer, M.D, PhD, FACC, PA
3413 20th Street
Lubbock, TX 79410
FAX: 806-701-2560

Please stress that your records must arrive in Dr. Wischmeyer's office at least one week (5 working days) prior to your scheduled first visit. It is important that ALL of the forms you received in your initial packet from our office also must be completed and returned to our office one week prior to your first visit with Dr. Wischmeyer.

Dr. Wischmeyer carefully studies your medical history and incorporates it into his assessment of your risk of heart attack, strokes or diabetes. By obtaining your medical records, this office can also avoid the unnecessary duplication of tests, which will save you money and time.

Office Visit: The first office visit is primarily an educational process. Please allow approximately 1-2 hours for this appointment. You will learn what happens inside your heart and cardiovascular system when cardiovascular disease is present. You will also learn how to avoid cardiovascular disease, arrest or stop the disease and reverse the disease. During this appointment you will become familiar with terms such as insulin resistance, genotyping, CIMT and advanced lipid testing. The educational portion of this visit may be presented in a variety of formats including power-point presentation, DVD, written materials (which you will be able to take home) and one-on-one conversation. You are welcome to bring a spouse or friend (only one please) to this session. Dr. Wischmeyer will formulate a treatment plan specifically for you and explain it to you in detail.

Toward the end of this office visit you will receive a cardiovascular physical examination. Panel of tests are required. Several tests on this panel are ordered from a lab in Cleveland. Tests take approximately two weeks to be processed. *Labs may be drawn Monday through Friday at Quest Laboratory.* You will also be asked to undergo a simple non-invasive CIMT test. It is important that the test results from the blood drawn and CIMT are available to Dr. Wischmeyer prior to your second office visit. A Bale-Doneen trained dentist appointment will also be required.

Second Office Visit: The second office visit starts with a one-one-one review of all your test results.

Dr. Wischmeyer will develop a treatment plan for the coming year as well as providing you copies of all your tests results.

Annual Concierge Practice Option: After the completion of your Second Office Visit, you are welcome to discuss the option of continuing your cardiovascular prevention care with Dr. Wischmeyer. Please feel free to ask questions from either Dr. Wischmeyer or his staff.

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Office Policy on Payment

Insurance Policy:

We do not contract with any insurance companies. It is the patient's full responsibility to submit his/her claims to their insurance carrier. At the time of service, this office will provide the patient with two copies of the billing statement including appropriate service and diagnostic codes. Upon request, this office will provide each patient with a copy of his/her medical record for insurance purposes. It is the responsibility of the patient to submit these records/statements to their insurance carrier(s).

Authorization for Release of Medical Records:

I authorize Dr. Jason Wischmeyer to release my medical information including but not limited to billing, diagnosis, x-ray, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for the following purposes: diagnostic, insurance, legal and when my physician deems it necessary in order to ensure the best medical care on my behalf. Continuation of care is included in the justification for this release of information to other care providers. I further understand that any person(s) or organization(s) that receive my medical records will not release any of the information obtained by this authorization to any other person(s) or organization(s) without further authorization signed by me for release of the information. In addition, I authorize the release of any medical information necessary to process my insurance claims. I understand I can revoke this authorization at any time.

In addition, I understand that while Dr. Jason Wischmeyer's treatment / methods strive to prevent diabetes, stroke and heart attacks, Dr. Wischmeyer and I understand there is no infallible method of prevention.

Medicare Patients: I further understand and agree that I will not submit any of Dr. Wischmeyer's concierge fees or fees for services provided by his clinic to Medicare or any Medicare supplemental insurance company. No legal action on my part is to be taken regarding Medicare or any Medicare Supplemental insurance company's exclusion of concierge fees or services provided by non-Medicare contracted providers for consideration or denial of coverage.

Signed_____Date_____

Call 806.535.1388 for scheduling and refills

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Invoice

Jason B. Wischmeyer, M.D, PhD, FACC, PA
Cardiovascular Disease
Interventional Cardiology
Peripheral Vascular Disease

3413 20th Street
Lubbock, TX 79410

806.535.1388

National Physician Identifier: 1265480966

Patient: _____ DOB: _____

Date

_____	Service Provided: 99387 Initial Preventative Service	$1500.00
_____	Service Provided: 99397 Established Preventative Service	$1500.00
_____	Total service due at end of second visit	$3000.00

*** These services may be provided in one visit if opportunity of time and results allow.

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

EPWORTH SLEEPINESS SCALE

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these things recently, try to work out how they would have affected you.

Name: _____ Date of Birth: _____ Today's Date:_____

Instructions: Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

It is important that you circle a number (0 to 3) on each of the questions

Situation	Chance of dozing (0-3)
Sitting and Reading	0 1 2 3
Watching Television	0 1 2 3
Sitting inactive in a public place-for example, a theater or meeting.	0 1 2 3
As a passenger in a car for an hour without break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. Please add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key

A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness.

A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your Symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Depression Self-Rating Test

Nearly 20 million Americans experience depression, but many will never seek treatment. The Depression Self-Rating Test is a simple l6-question quiz that can help identify common symptoms of depression and their severity. Remember depression is more than just feeling down-it is a real medical condition that can be effectively treated.

Please complete the following questionnaire and return it to your healthcare provider.

Name: _____ Date of Birth: _____ Today's Date: _____

Instructions: Please circle the one response to each item that best describes you for the past seven days.

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Jason Wischmeyer M.D., Ph.D., F.A.C.C.

1. Falling asleep:
- **0** I never take longer than 30 minutes to fall asleep.
- **I** take at least 30 minutes to fall asleep, less than half the time.
- **2** I take at least 30 minutes to fall asleep, more than half the time.
- **3** I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep during the night:
- **0** I do not wake up at night.
- **1** I have a restless, light sleep with a few brief awakenings each night.
- **2** I wake up at least once a night, but I go back to sleep easily
- **3** I wake up more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking up too early:
- **0** Most of the time, I wake up no more than 30 minutes before I need to get up.
- **1** More than half the time, I awaken more than 30 minutes before I need to get up.
- **2** I almost always awake at least one hour or so before I need to, but I go back to sleep eventually
- **3** I woke up at least one hour before I need to, and can't go back to sleep.

4. Sleeping too much:
- **0** I sleep no longer than 7-8 hours/night, without napping during the day.
- **1** I sleep no longer than 10 hours in a 24-hour period including naps.
- **2** I sleep no longer than 12 hours in a 24-hour period including naps.
- **3** I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:
- **0** I do not feel sad.
- **1** I feel sad less than half the time.
- **2** I feel sad more than half the time.
- **3** I feel sad nearly all of the time.

6. Decreased appetite:
- **0** There is no change in my usual appetite.
- **1** I eat somewhat less often or lesser amounts of food than usual.
- **2** I eat much less than usual and only with personal effort
- **3** I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat

7. Increased appetite:
- **0** There is no change from my usual appetite.
- **1** I feel a need to eat more frequently than usual.
- **2** I regularly eat more often and/or greater amounts of food than usual.
- **3** I feel driven to overeat both at mealtime and between meals.

8. Decreased weight (within the last two weeks):
- **0** I have not had a change in my weight.
- **1** I feel as if I've had a slight weight loss.
- **2** I have lost 2 pounds or more.
- **3** I have lost 5 pounds or more.

9. Increased weight (within the last two weeks):
- **0** I have not had a change in my weight
- **1** feel as if I've had a slight weight gain.
- **2** I have gained 2 pounds or more.
- **3** I have gained 5 pounds or more.

10. Concentration/Decision making:

0 There is no change in my usual capacity to concentrate or make decisions.
1 I occasionally feel indecisive or find that my. attention wanders.
2 Most of the time, I struggle to focus my attention or to make decisions.
3 I cannot concentrate well enough to read or cannot make even minor decisions

11. View of myself:

0 I see myself as equally worthwhile and deserving as other people
1 I am more self-blaming than usual.
2 I largely believe that I cause problems for others
3 I think almost constantly about major and minor defects in myself

12. Thoughts of death or suicide:

0 I do not think of suicide or death,
1 I feel that life is empty or wonder if it's worth living.
2 I think of suicide or death several times a week for several minutes.
3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life

13. General interest:

0 There is no change from usual in how I am interested in other people or activities.
1 notice that I am less interested in people or activities.
2 I find I have interest in only one or two of my formerly pursued activities.
3 I have virtually no interest in formerly pursued activities

14. Energy level:

0 There is no change in my usual level of energy.
1 I get tired more easily than usual.
2 I have to make a big effort to start or finish my usual daily activities (for example: shopping homework, cooking, or going to work).
3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

0 I think, speak, and move at my usual rate of speed
1 I find that my thinking is slowed down or my voice sounds dull or flat
2 It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.
3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:

0 I do not feel restless.
1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
2 I have impulses to move about and am quite restless.
3 At times, I am unable to stay seated and need to pace around.

This section is to be completed by your doctor.

To Score:

Enter the highest score on any I of the 4 sleep items (1—4) _____
Item 5 _____
Enter the highest score on any I appetite/weight item (6—9) _____
Item 10 _____
Item 11 _____
Item 12 _____
Item 13 _____
Item 14 _____
Enter the highest score on either of the 2 psychomotor items (I5 and 16) _____
TOTAL SCORE (Range 0—27) _____

Scoring Criteria: Normal 0-5 Mild 6-10 Moderate 11-I5 Severe 16-20 Very Severe 21+

NOTE: The above cutoff points are based largely on clinical judgment rather than on empirical data. Copyright © 2000 A. John Rush, MD. Quick Inventory of Depressive Symptomatology (Self-Report) (QIDS-SR). Used with permission. Reference: 1. National Institute of Mental Health website. Depression research at the National Institute of Mental Health Fact Sheet. Available at http://www.nimb.nih.gov/publical/depresfact.cfm. Accessed November 28, 2002.

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Medical History

PLEASE COMPLETE ALL PAGES

Name:_____Date:_____DOB:_____

Please be as specific as possible as this form will give us a better understanding of your medical concerns and conditions. If you are uncomfortable with any questions, do not answer them. Please contact family members if you need assistance in completing the Family History section. You may attach additional pages as necessary.

THANK YOU!

How would you rate your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current age:_____ Weight:_____ Height:_____ Ethnicity:_____

Waist Measurement:_____ Date of Last Physician Exam:_____

Medications: Prescription and Non-prescription medications, vitamins, home remedies, birth control pills, herbs.

Medication: Dose (e.g. Mg/pill) How many times/days When Started Why Using

_____

_____

_____

_____

_____

_____

_____

_____

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Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Allergies or Adverse Reactions to Medicines: _____

_____

Date of most recent screening for the following:

Cholesterol_____ Chest X-Ray _____ EKG _____

Spirometry_____ Bone Density_____

Any other VASCULAR TEST_____

Personal Medical History:

Please indicate whether you have had any of the following medical problems (with dates):

- ☐ Heart Disease_____
- ☐ Bleeding/Clotting Problems_____
- ☐ Alcoholism *specify type* _____
- ☐ Rheumatoid Arthritis _____
- ☐ Gout _____
- ☐ Aortic Aneurysm _____
- ☐ High Blood Pressure _____
- ☐ Blood Transfusion _____
- ☐ Polycystic Ovaries _____
- ☐ High Cholesterol _____
- ☐ Poor Blood Flow to Extremities _____
- ☐ Cancer (*Malignancy*) _____
- ☐ Diabetes *specify type* _____
- ☐ Thyroid Problems _____
- ☐ Depression / Suicide Attempts _____
- ☐ Unexplained Nerve Problems *specific types* _____
- ☐ Lupus _____
- ☐ Psoriasis _____
- ☐ Migraine Headaches _____
- ☐ With Aura Without Aura
- ☐ Fatty Liver _____
- ☐ Pre-diabetes _____
- ☐ Chronic Dental Problems _____
- ☐ Osteoporosis _____
- ☐ Autoimmune Disorder_____
- ☐ H. Pylori Infection _____
- ☐ Other _____

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Have you ever had the following procedures? If so, please list the dates:

☐ Coronary Artery Bypass Surgery_____

☐ Angioplasty or Stent_____ ☐ Angiogram_____

Have you ever been hospitalized for illness? ☐ Yes ☐ No If so, list when and reason:

_____

_____

Surgical History: Please list all other operations (with dates)

_____

_____

_____

Social History:

Tobacco use: Cigarettes ☐ Never ☐ Quit: Date: _____ Pack/Years ___

☐Current Smoker: Pack/ day_____ Other Tobacco ☐ Pipe ☐ Cigar ☐Chew # of years_____

Are you interested in quitting? ☐ No ☐ Yes Second-hand smoke exposure? ☐ No ☐ Yes

Alcohol use: Do you drink alcohol ☐ No ☐ Yes # of drinks/week_____

Is alcohol a concern for you or others? ☐ No ☐ Yes

Sexual History:

Male: do you have a problems with erections? ☐ No ☐ Yes Date of Onset:_____

Female: Birth Control Method: _____ None Needed_____

#of pregnancies _____ #of deliveries_____ #of miscarriages_____

Problems with pregnancy or deliveries? _____ Osteoporosis_____ Osteopenia_____

Any history of gestational diabetes? ☐ No ☐ Yes Eclampsia? ☐ No ☐ Yes

Children: Weighing Over 10 lbs. at birth? ☐ No ☐ Yes

_____

1st day of most recent period:_____ Age at 1st period:____ Frequency:_____

Length of each:_____

Other Concerns

Caffeine Intake: ☐ None ☐ Coffee/Tea_____ cups/day ☐ Sodas___# per day ☐ Chocolate _____oz/day

Weight: Are you satisfied with your weight? ☐ No ☐ Yes

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Do you take supplements? ☐ No ☐ Yes(if so, what kind?)_____

Do you drink 4 large glasses of milk daily or take calcium supplements? ☐ No ☐ Yes

Exercise Do you exercise regularly? ☐ No ☐ Yes

What kind of exercise?_____

How long? Minutes?_____

How often?_____

If you don't exercise, why?_____

Socioeconomics:

Occupation:_____ Employee:_____

Years of Education/Highest Degree:_____ Marital Status ☐ S ☐ M ☐ D ☐ W

Spouse/partner's name:_____ Who lives at home with you?_____

Number of Children:_____ Ages:_____ _____ _____ _____ _____ _____

How would you classify the stress at work? ☐ Minimal ☐ Medium ☐ High

How would classify the stress at home? ☐ Minimal ☐ Medium ☐ High

Do you feel anxious, angry, irritated or rushed? ☐ No ☐ Yes

Nutrition: How many daily servings of the following do you have?

_____Whole grains _____Fruits _____Vegetables

How many times in one week do you consume the following items?

____Eggs ____Fish ____Chicken/Turkey ____Red Meat ____Butter ____Margarine

____Other high fat dairy products ____Other low fat dairy products ____Fried Foods

____High fat snacks What type of cooking oil do you use?_____

Review of Symptoms: Please Check ( ) any current problems you have on the list below:

Constitutional :

☐ Fever/Chills/Sweats ☐ Change in skin texture ☐ Change in hair texture

☐ Unexplained weight loss/gain ☐ Inability to stand heat ☐ Change in energy / weakness

☐ Brittle nails ☐ Inability to stand cold ☐ Excessive thirst or urination ☐ Dry skin

Respiratory:

☐ Cough/Wheeze ☐ Difficulty Breathing ☐ Snoring

☐ Eyes: Change in vision ☐ Ears/Nose/Throat/Mouth: ☐ Difficulty hearing/ringing in ears

☐ Problems with teeth/gums ☐ Hay fever / Allergies ☐ Growth in throat / neck

Cardiovascular:

☐ Chest pain / discomfort ☐ Palpitations

Chest:(Breast)

☐ Breast lump / nipple discharge

Skin:

☐ Rash/mole change ☐ Acanthosis nigricans

Genitourinary:

☐ Unusual frequency of urination

Sexual:

☐ Problems with erectile function

Gastrointestinal:

☐ Abdominal pain ☐ Diarrhea / constipation ☐ Blood in bowel movement

☐ Heartburn ☐ Nausea/Vomiting

Neurological:

☐ Headaches ☐ Loss of coordination ☐ Light-headedness

☐ Tingling/Pain/Numbness in hand or feed ☐ Memory loss

Psychiatric:

☐ Problems with sleep ☐ Depression

☐ Panic attacks ☐ Mania

Blood/Lymphatic:

☐ Easy bruising/bleeding ☐ Unexplained lumps

Any other symptoms? If yes, please explain:_____

_____

Cardiovascular Disease Prevention

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Family History

Please indicate the current status of your immediate family members:

	Alive	Deceased	Age (present or at death)	Comments/Cause of death
Mother's Mother				
Mother's Father				
Father's Mother				
Father's Father				
Father				
Mother				
Sister				
Sister				
Sister				
Brother				
Brother				
Brother				
Daughter				
Daughter				
Daughter				
Son				
Son				
Son				

♥ Please use this space to add any additional family members:

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Family History

Please indicate with a (check) family members who have had any of the following:

Medical Condition														
Alcoholism														
Anemia														
Aortic Aneurysm														
Alzheimer's														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problems														
Carotid artery disease														
Carotid artery disease														
Cancer														
Gout														
Heart attack														
Depression														
Diabetes-Type 1 (Childhood Onset)														
Diabetes-Type 2 (Adult Onset)														
Other genetic disease														
High Cholesterol (hyperlipidemia)														
High blood pressure (hypertension)														
Immunosuppressive disorders														
Kidney disease														
Osteoporosis														
Peripheral vascular disease														
Epilepsy (seizure disorder)														
Stroke														
Substance Abuse														
Thyroid disorder														
Smoking														
Sleep Apnea														

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Demographics Form

Please Print

Name:_____ ☐ Male ☐ Female
First Middle Last

Address:_____ City:_____ State:_____ Zip:_____

D.O.B:___/___/_____ Age:_____ Social Security#:_____-_____-_____ Marital Status: S M D W
circle

Home Phone: (____)_____ Email Address:_____

Cell Phone: (____)_____ Other Phone: (____)_____

Employer_____ Work Phone: (____)_____

Emergency Contact (Friend / Relative):_____Phone: (____)_____

Parent / Spouse Name:_____
First Middle Last

Insurance Co.: _____ ID#:_____ Group#:_____

Subscriber's Name:_____ Subscriber's Date of Birth:____/___/_____

Person responsible for the bill?: ☐ Self ☐ Spouse ☐ Other_____

Name (if different from above):_____

How did you hear about our center? _____

_____

_____

_____

_____

Patient's Signature:_____ Date:_____