



Dear New Patient:

Thank you for choosing Sunrise Complementary Medical Center (SCMC) as your healthcare provider. Our staff is dedicated to making your experience a most satisfying one. SCIMs team of healthcare practitioners will assure that you receive care that is specifically tailored to your health needs.

The enclosed information is necessary in order for us to complete your in office file and for our participation in your health care. You are encouraged to make copies of these documents for your records. **NOTE: The following forms must be completed, signed, and received by our office prior to scheduling an appointment.** We apologize for any inconvenience this may cause, but we need to accommodate other patients waiting to be scheduled. **You may fax, mail or email these forms to the office.**

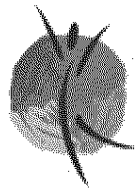
- **Patient Information Form** (*return to office*)
- **Office Policies and Procedures** (*return to office*)
- **Health History Questionnaire** (*return to office*)
- **Universal Health Association Membership Application** (*return to office*)
- **Credit Card Authorization** (*return to office*)
- **Patient Consent Form** (*return to office*)

If you have copies of recent medical and laboratory reports, please provide them to our office at least one day prior to your appointment. If you cannot provide them prior to your appointment, you may bring them with you.

Please don't hesitate to contact us should you have any questions. We look forward to assisting you.

**Sunrise Complementary Medical Center
41661 Enterprise Circle North Ste 113
Temecula CA 92590
(951) 461-4800 - phone
(951) 461-4560 – fax**

Revised 04/01/11



SUNRISE

Complementary Medical Center

(Office Policies and Procedures)

Hours:

- Monday, Wednesday and Friday 9AM-1PM
- Tuesday and Thursday: 9AM–5PM (PST)
- Consults are by appointment only.

Consultation Fees, Test Kits, and In-Office Therapies:

We accept check, mastercard, and visa. For patients needing a payment plan we accept CareCredit for physician consults. (see below).

CareCredit:

CareCredit (www.carecredit.com) is a medical financing service available through our office that you can put towards office consultations, laboratory testing, and in-office therapies. Our practice is listed as **Universal Health Association** under **General Medicine** on the **CareCredit** website.

Appointments:

- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, CareCredit, and check. No cash please.
- First appointment: All initial paperwork must be completed, signed, and received by office before your appointment will be scheduled. You may fax, mail or email the forms to the center.
- First appointment: If paying by check for a phone consultation, include the check with your mailed paperwork.
- Follow-up consults may be scheduled as ***brief/focused, detailed, and comprehensive/complex*** depending on your particular situation.
- Patients who forget their appointment or cancel less than 2 business days prior to their appointment will be required to pay for the missed visit. Please understand that a missed appointment could have gone to a patient on the waiting list. The 48-hour reminder email/call from SCMC is a courtesy reminder only and not a guaranteed affirmation of your appointment.
- Consultations with other healthcare providers and/or any research requested by the patient are billable services and will be charged at the hourly rate.
- Scheduled consultations that include review of lab tests require that laboratory test results be received at least 24 hours prior to appointment.

Medical Letters, Narrative Reports, Chart Note Copying, etc.

Medical letters to schools, insurance companies, disability, as well as narrative reports and chart note copying for insurance purposes, etc. are a billable service. If your insurance company requires additional information we will attempt to bill them prior to sending the requested information. Unfortunately, some insurance companies feel that paying for this service is not an allowable. If this occurs than any fees will be your responsibility.

Office Consultations:

- Please check in 15 minutes before your scheduled appointment.
- Patients who are late may lose part of their time, and may be billed at the rate of the scheduled appointment.
- **Please do not wear any scented products, as many of our patients are chemically sensitive. These include lotions, cologne, perfume, hair spray, etc.**

Phone/ Skype or Internet Consultations:

- **There is no price difference for phone or skype.com consultations. Each phone/internet consultation is treated like any other consultation – the time spent with your doctor is the same whether it is in person (in the office) or over the phone/internet. The phone/internet consultation is for the patient's convenience. If you would rather have an office consultation then let the office staff know your preference.**
- Your doctor will call you at the time of your scheduled consultation.
- All appointments are scheduled for the Pacific Standard Time zone.
- We require patients outside of the USA to call the office at the time of their scheduled phone consultation. If this is not possible, than phone consultation phone bill charge will be billed to the patient. (For internet consults the doctor will contact you)

Cancellations:

- As a courtesy, our office will email/call you to confirm your appointment 2 business days in advance.
- If you cannot keep a scheduled appointment, you must notify us a minimum of 2 business days prior to your scheduled time, or you will be charged for the missed appointment.
- If your appointment is on Monday, please notify our office no later than noon on the previous Thursday.

Prescription Request:

- Prescriptions originating from a consultation are processed at no charge. However, refills of these original prescriptions requested by you that are approved by your doctor without consultation may incur a processing charge per prescription.
- Requests for a new prescription or a change in prescription type or transfer to a different pharmacy or multiple refills may incur a prescription processing charge.

Questions and Follow-up:

- Please direct e-mails, faxes regarding you or your care to the Center's administrative assistants info@mysunnisecenter.com Questions must be brief and concise. The office staff and/or clinic physicians will determine if a phone or office consult is needed to answer your question(s). Otherwise, a member of our office staff will respond to your inquiry. When leaving a voice mail message, please be brief and concise and always include your name and phone number, including the area code.
- **Please Note:** We try to accommodate questions regarding treatment clarification at no charge. Simply put, if you have a quick question about a supplement or diagnostic test we recommended or a therapy reaction you may be experiencing, then by all means contact us. However, if the response to a question you submit requires doctor research and/or review, you may be billed for the time involved at the doctor's hourly rate.

Follow-up Consultations:

- We generally recommend that all patients minimally have a consultation with their respective clinic doctor every 3 months to 6 months.
- If prescription medication is being provided by your clinic doctor for yourself or your child than a consultation is required in the following manner:
 - **Every 6 to 12 months – Unless your physician deems it necessary a follow up sooner.**

- Follow up consults are necessary for your doctor to monitor medications, and/or make any necessary changes to your treatment program.

Payment:

- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, CareCredit, and check. No cash please.
- If paying by check for a phone consultation, include the check with your mailed paperwork.
- If you are unable to pay by credit card, a check must be provided prior to your appointment in the amount due for the scheduled time. In the event that your consultation exceeds or falls short of the scheduled time, adjustment to payment will be made on the same day via Electronic Funds Transfer (EFT).

Insurance:

- For patients that have seen the medical director, a “Superbill” receipt (form detailing diagnostic codes and fees) can be provided to you after each visit. This receipt can be submitted to your insurance carrier for reimbursement. Some services may not be covered by certain health insurance plans. It is your responsibility to know what your insurance plan covers. We are not responsible for unpaid claims by your insurance company for services we provide. SCMC does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.
- SCMC healthcare practitioners are **non-participating** Medicare, Medi-Cal, Champus, and Tri-Care providers. They can treat these patients who privately contract outside of these programs on a cash basis only. Standard receipts can be provided. However, diagnostic code receipts called “Superbills” cannot be provided as these organizations will not allow for patient reimbursement. **There is a waiver on the last page of this document titled “Patient Private Contract” that must be completed if you are a member with the above insurance plans.**

Acceptance of Policies and Procedures

By completing the following you agree to the policies and procedures detailed above.

Patient (please print): _____ Date: _____

Signature (patient or responsible party): _____

If signed by party other than patient, print name: _____



SUNRISE
Complementary Medical Center

Patient Private Contract
(Medicare/MediCal/Tricare)

(Patient Name or Legal Guardian)

With: Kurt N. Woeller, D.O.
41661 Enterprise Circle North STE 113
Temecula CA 92590

Under Code 1128 of the Social Security Act,
Dr. Woeller has requested exclusion from participation in the Medicare Program

I have voluntarily decided to privately contract outside the Medicare Part B program for the professional services of osteopathic medicine, even if such items and services would otherwise be covered by **Medicare/MediCal/TriCare**. Neither my family nor heirs nor estate will file any Medicare Part B forms for these services nor require Dr. Kurt Woeller, D.O. or his office staff to do so.

I hereby waive my entitlement to Medicare Part B benefits for these services.

By signing this contract, I also agree that:

I am responsible for payment of office fees for services.
Medicare will make no reimbursements for any items or services.

No Medicare payment limits are applicable.

Medigap plans and other supplemental plans **will not make payments** for these items and services since Medicare will make no payment.

I may have such services provided by another physician for which Medicare payment would be made.

Osteopathic Manipulative Medicine is a covered Medicare service and other participating physicians may choose to bill Medicare for these osteopathic services.

I acknowledge that a legal representative or I signed this agreement at a time when I was not facing any medical emergency or urgent healthcare situation.

Patient or Legal Guardian

Date

Kurt N. Woeller, D.O.

Date



The Universal Health Association

Universal Health Association
41661 Enterprise Circle N. Ste 113
Temecula, CA. 92590
951-461-4800 * 951-461-4560 (fax)
www.universalhealthassociation.org

The purpose of the Universal Health Association (UHA) is to protect the rights of patients to obtain and the rights of health practitioners to provide a wide array of cutting-edge healthcare services, therapies and diagnostics at a reasonable price, while protecting patient's healthcare practitioners from frivolous legal actions by those who do not appreciate the unique diagnostic and therapeutic options that we provide.

In addition to conventional medical care, Sunrise Complementary Medical Center offers its discerning clientele access to cutting-edge diagnostic testing and therapies. To offer these services while protecting doctors and other health care practitioners from unreasonable liability, it would be necessary to carry very costly medical liability insurance. This cost typically would be passed on to patients in the form of substantially increased fees. The UHA offers a solution to this potential cost spiral.

A growing segment of the American population (and others around the world) demand access to both conventional, as well as cutting-edge healthcare services. However, a doctor may be found "negligent" for utilizing diagnostic procedures and/or treatments that are not considered to be conventional: those defined as "standard" and "customary" within his/her community.

Members of the UHA (which includes all patients, staff members, doctors, and other health care practitioners), through their by-laws, agree to limit the scope and extent of legal remedies against fellow members of the Association. All complaints against other members, including healthcare practitioners, must be initiated with the UHA. By becoming a member of the UHA you agree to the Association's by-laws, including its grievance procedures as set forth in Article XXVII (Grievances). For convenience, your healthcare provider has agreed to pay your \$5 lifetime membership fee to the UHA. UHA by-laws are provided on the internet at www.universalhealthassociation.org and are available in printed form at Sunrise Complementary Medical Center.

MEMBERSHIP APPLICATION

Name: _____
Business Address: _____
Business Phone: _____
Home Address: _____
Home Phone: _____
e-mail: _____

MEMBERSHIP CERTIFICATION

I, (print name) _____, have been informed of the benefits and responsibilities of the membership in the Universal Health Association. I have been informed of the by-laws under which the Association operates and understand the nature of those by-laws, that include but are not limited to, the use of administrative remedies and Arbitration to resolve disputes. In consideration for the benefits of membership, I agree to join the Universal Health Association as of the date below. I also agree to abide by all of the Association's by-laws, rules and regulations as they exist now and as they may be amended in the future.

Executed on (date) _____ at (City and State) _____

Name (print): _____

Signature: _____

Note: Membership information is held in confidence and not provided, leased, or resold to any third party or entity, unless otherwise required by law. Its use is solely for Association business and communicating to members.



SUNRISE
Complementary Medical Center

Patient Contact Information

(PLEASE PRINT CLEARLY)

Patient Name _____
Last First Middle initial

Home address _____ Birth date ____/____/____

City _____ State _____ Zip _____

Driver's License # _____ State _____

Primary phone: Daytime () _____ Evening () _____

Cell phone () _____ Fax () _____

Email address _____

Employed by _____ Occupation _____

Insurance Provider _____ If PPO Plan, do you wish to have a diagnostic code receipt so you may seek reimbursement Yes _____ No _____

What name do you prefer to be called?

Who referred you to our office?

In case of emergency contact:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home phone () _____ Work phone () _____

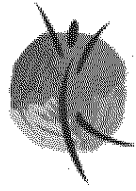
For children under 18 years of age:

Mother's full name _____

Father's full name _____

School attending _____ City _____

For office use only:



SUNRISE
Complementary Medical Center

(Credit Card Authorization)

I, (print name) _____ authorize Sunrise
Complementary Medical Center (SCMC) , located at 41661 Enterprise Circle North Ste 113
Temecula, California to bill my credit card as listed below.

Name on Credit Card _____

Credit Card Details

Visa Card # _____ Exp date _____

MasterCard Card # _____ Exp date _____

Discover Card # _____ Exp date _____

Driver's License # _____ State: _____

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (include area code): _____

Authorization

Card Holder's Signature

Today's Date

Patient's Signature

Today's Date

This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.



THIS FORM IS REQUIRED BY LAW AND SERVES TO PROTECT YOUR RIGHT TO PRIVACY.

Sunrise Complementary Medical Center (SCMC) protects the privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, or telephone number. SCMC will not disclose this information without your authorization, except as permitted by law.

Our **Notice of Privacy Practices** provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about you is used or disclosed. Please review the Notice of Privacy Practices before signing this consent.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal information is **not** shared with third parties such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Print name

Signature

Date



SUNRISE

Complementary Medical Center

Effective Date: April 1, 2011

Please Note: In order to comply with the numerous state, Federal, and local laws that govern medical information privacy, this document is provided. Sunrise Complementary Medical Center (SCMC), its healthcare practitioners, and all associated personnel will do everything possible to maintain the privacy of your medical information as required by law. Under no circumstances will SCMC disclose your personal or medical information to any outside parties.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE.

This notice describes SCMC practices and that of:

- Any health care professional authorized to enter information into your patient chart.
- All employees, staff and other clinic personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other clinic personnel who are involved in taking care of you at the clinic. Different departments of the clinic also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Health Care Operations. We may use and disclose medical information about you for clinic operations. These uses and disclosures are necessary to run the clinic and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and service about many clinic patients to decide what additional services the clinic should offer, what services are not needed, and whether certain new treatments are effective.

We may also disclose information to doctors, nurses, technicians, medical students, and other clinic personnel for review and learning purposes. We may also combine the medical information we have with medical information from other clinics to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are, and to evaluate the performance of our staff in caring for you. We may also combine medical information

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the clinic.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under limited circumstances, we may use and disclose medical information about you for research purposes. Note: Under no circumstances will your name be associated with your medical data. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the clinic.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

SPECIAL SITUATIONS

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the clinic. To request an amendment, your request must be made in writing and submitted to the address below. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the clinic; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the address below. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the clinic. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with the clinic, call 800-831-8798. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



SUNRISE
Complementary Medical Center

(Health History Questionnaire)

(Please Print)

Patient Name: _____ Date: _____
Birth Date: M _____ D _____ Y _____ Sex: Male _____ Female: _____

Weight _____ Height _____ Blood Pressure (if known) _____ Body Fat% (if known) _____

Primary Health Concerns:

When did your health concerns begin?

Please use this space below to share additional information with us regarding your health concerns.

Occupation: _____

Please Describe Your Hobbies: _____

Pulmonary (Lung)

- NO PROBLEMS
- Asthma (wheezing)
- Chronic bronchitis
- Chronic cough
- Emphysema
- Tuberculosis
- Other _____

Cardiovascular Health

- NO PROBLEMS
- Hypertension (high blood pressure)
- Hypotension (low blood pressure)
- Heart Attack when? _____
- By-pass surgery when? _____
- Angioplasty (balloon) When _____
- Angina pectoris
- Tachycardia (rapid heart rate)
- MVP (Mitral Valve Prolapse)
- Congestive Heart Failure
- Heart Palpitations

Circulatory

- NO PROBLEMS
- High Cholesterol
- High triglycerides (fats)
- Poor arterial circulation
- Poor venous circulation
- Leg cramps
- Tired legs
- Swollen ankles
- Varicose veins
- Numbness of hand or leg
- Tingling sensations in hands or feet
- Leg ulcers

Gastrointestinal

- NO PROBLEMS
- Problems with digestion
- Acid indigestion/heartburn
- Belch after meals
- Bloating
- Stomach or duodenal ulcer
- Loss of appetite
- Rapid weight gain
- Rapid weight loss
- Overweight problem
- Nausea
- Pain
- Pancreas problems
- Hepatitis gall stones
- Jaundice (turning yellow)
- Recurring diarrhea
- Constipation (compact stools)
- Leaky gut syndrome

Urinary

- NO PROBLEMS
- Recurrent bladder infections
- Renal (kidney) failure
- Stress incontinence
- Kidney stones
- Chronic fungal infections
- Weak adrenal glands
- Female menopause
- Other _____

Gynecologic

- NO PROBLEMS
- Menstrual periods every _____days
- Menstrual periods have ceased
- Premenstrual tension
- Vaginal yeast infections
- Water retention
- Urinary frequency
- Irregular menstrual cramping
- Painful menstrual cramping
- Breast masses
- Painful breast swelling
- Fibrocystic breasts
- Hot flashes
- Mood changes or irritability
- Loss of vaginal lubrication
- Fibroid tumors
- Polycystic ovary disease (PCO)
- Endometriosis
- Hysterectomy only
- Hysterectomy & removal of ovary(s)
- Tubal ligation
- Other _____

Obesity or Weight Loss

- Weight at 18? _____
- Weight gain or loss for how long? _____

Endocrine

- NO PROBLEMS
- Diabetes mellitus
- Insulin dependent
- Non- insulin dependent
- Thyroid dysfunction
- Overactive
- Underactive
- Dry skin
- Cold hands and/or feet
- Hair falling out or thinning

- Low body temps
- Depression

Skin

- NO PROBLEMS
- Chronic rash
- Eczema
- Psoriasis
- Skin cancer
- Dandruff or seborrhea
- Dry skin
- Oily skin
- Blemishes (acne)
- Lupus (SLE)
- Rosacea
- Fungal nail infections

Neuro-Psychiatric

- NO PROBLEMS
- Frequently nervous or anxious
- Depression
- Memory lapses or loss
- Decreased ability to concentrate
- Tension headaches
- Migraine headaches
- Sleep disturbances
 - Trouble falling asleep
 - Trouble maintaining a restful sleep
- Chronic or recurrent dizziness
- Reduced vitality – chronic fatigue
- Other _____

Sexual

- NO PROBLEMS
- Decreased in or loss of libido
- Decreased sexual vigor
- Orgasmic Problems

Cancer (Past or Present) [very important]

- NO PROBLEMS
- lung
- Breast
- Prostate
- Brain
- Colon
- Stomach
- Skin
- Liver
- Bone
- Blood (leukemia)
- Hodgkin's
- Bladder
- Other _____

When first diagnosed _____

Treatment _____

Duration of Treatment _____

Last Checkup _____

Previous Prescription Medications:

Current Prescription Medications:

Anticoagulants? Since when _____

Rheumatoid, Joint and Back

- NO PROBLEMS
- Muscle pains
- Joint pains
- Neck pains
- Back pains
- Rheumatoid arthritis
- Lupus (SLE)
- Scleroderma
- Fibromyositis or Fibromyalgia
- Other

General Information:

- Past or Present Problems with:
- Medications
- Foods
- Soaps
- Clothing
- Vaccinations
- Multiple chemicals
- Trees
- Pollens
- Molds
- Animals
- Hay fever
- Asthma

WOMEN'S HEALTH & PRECONCEPTION QUESTIONNAIRE

FEMALE REPRODUCTIVE HISTORY

Are you currently pregnant? _____ If yes, how many weeks? _____

Date of last menstrual period? _____

CHILDREN:

Sex / Age / Health problems (autism, asthma, allergies, congenital etc)

____ / ____ / _____

____ / ____ / _____

____ / ____ / _____

How many:

Perinatal Deaths: _____ Dates: _____

Miscarriages: _____ Dates: _____

Premature Births: _____ Dates: _____

Therapeutic Terminations: _____ Dates: _____

Stillbirths: _____ Dates: _____

Small baby at term: _____ Dates: _____

Problems during pregnancy:

Did you breastfeed?

Problems with breastfeeding: Explain _____

INFERTILITY: (Y/ N) _____ Years: _____

Female: _____ Male: _____

Previous fertility treatments used:

Type: _____ Duration/ no. times: _____ Result: _____

____ / ____ / _____

____ / ____ / _____

____ / ____ / _____

Current fertility drugs eg. Clomid, Danazol, Heparin etc

Any further information about past/ present fertility treatment:

Are you taking HRT (hormone replacement therapy) ? _____ If yes, what type and dose?
