Michael Cheikin M.D.
Holistic Medicine and Physiatry
Center for Optimal Health
832 Germantown Pike, Suite 3
Plymouth Meeting, PA 19462
610-239-9901 cohlife.org

Dear New Patient:

We are glad to hear that you are going to work with our Center to get to the root cause of your health issues. This letter will help you prepare for our initial consultation, which will include a check-in and check-out, in addition to spending between 45-80 minutes with the doctor. Please plan to arrive at least 30 minutes early to complete the registration process. Parking is easy and free! You will also need time after the first visit to check out. Plan on being at our office for about two hours.

Please Bring:

- ☐ completed paperwork–9 pages (not including this page)
- ☐ your insurance card
- ☐ photo ID
- ☐ HMO referral (if required, you will be billed for the visit without this or if you cancel - see below)
- ☐ required co-pay
- ☐ copies of ALL PRINTED lab reports if you have them (discs are not helpful)
- ☐ a chronological history in electronic format if your history is complex. You can use history.docx. DON'T print or bring a hand-written copy as you will be updating the information soon.

It would be helpful for you to think about in advance, and write down for the consultation:

- ☐ any burning questions that you have
- ☐ strange symptoms that you may be embarrassed to tell other practitioners or do not fit on forms
- ☐ any urgent issues that need to be addressed on the first visit

We will reserve at least 45 minutes of physician time for your initial consultation. Because this time is reserved just for you, **we require 2 full business days notice of cancellation (i.e. Thursday 10am for a Monday 10am appointment).** You have agreed to this cancellation policy that is in your initial Patient Registration. If you have not yet registered, it's easy and brief at cohlife.org/register **.**

We take your concerns, your time and other resources very seriously. We look forward to facilitating the learning and healing that within you. You wouldn't have contacted us if you didn't believe this was true!

We look forward to working with you.

Sincerely,

Michael Cheikin MD and Center Staff

PRIVACY PRACTICES
WYNDMOOR REHABILITATION ASSOCIATES, P.C. ("WRA")
dba THE CENTER FOR OPTIMAL HEALTH
and
WYNDMOOR PHYSICAL MEDICINE GROUP, P.C. ("WPMG")

Patient Name: ________________________ Date of Birth: ___________ Date Completed: _______________

Name of Personal Representative, if applicable: __________________________ Relationship: _______________

Please complete by hand or electronically.

PART A: ACKNOWLEDGMENT OF REVIEW OF NOTICE. ☐**Yes** ☐**No** Click here to see the Notice.
I hereby acknowledge that I have reviewed and can print the Notice of Privacy Practices of WRA and WPMG.

Patient or Personal Representative Signature: ______________________________________

Complete this section only if you want us to share information with other people involved in your care (parent, partner, etc.

PART B: AUTHORIZATION FOR RELEASE OF INFORMATION ☐**Yes** ☐**No**
I hereby authorize the use or disclosure, as appropriate, of my individually identifiable health information by WRA and/or WPMG as described below:
Authorization requested by: patient or representative.
Person/Organization (with address) to receive the information:

____

What information: ☐all medical records OR ☐ (specify:)____

Purpose: ☐ continuity of care OR ☐ (specify:)____

Complete this section if you want us to notify you about our programs and services. Your information will not be shared with any outside agency.

PART C: AUTHORIZATION FOR FOR NOTICES ABOUT OUR PROGRAMS ☐**Yes** ☐**No**
I hereby authorize the use of my **address and/or email** by WRA and/or WPMG as described below.
Authorization requested by: patient or representative.
Person/Organization to receive the information: WRA and/or WMPG will use your address and/or email only to send you information about our programs **but will not release it to other marketing firms. For legal purposes, this is still called "marketing".**
Specific description of information to be released (including date(s) if applicable: **Name, address, email, telephone numbers--no other health information will be used.**
Purpose of the use or disclosure: **to inform you of future programs and services offered by WRA and/or WPMG**
WRA and/or WPMG **will not** be receiving financial or in-kind compensation in exchange for using or disclosing the information described above.

Complete this section only if you have completed Part B or C.

Complete for Part B and Part C authorizations.
The patient or the patient's representative must read and initial each of the following statements:

________ I understand that this Authorization is voluntary, and my treatment is not conditioned on my signing this Authorization (unless it relates to my receiving treatment for research purposes as explained above).

________ I understand that if the entity listed to receive this information is not a health plan or healthcare provider, the information released may no longer be protected by federal privacy regulations.

________ I understand that the Authorization may be revoked by me in writing, as explained in WRA and/or WPMG's Notice of Privacy Practices, but the revocation won't have any effect on uses or disclosures prior to the revocation.

________ I understand that the Authorization will expire on __ __/__ __/__ __ (leave blank if you do not want an expiration date).

________ I understand that I will can receive a copy of this Authorization upon request. Notice is available online as well.

____ Date: ________________________
Signature of Patient or Patient's Representative(s) (Both Parents if Patient is a minor)**

Printed Name of Representative(s) if applicable:____

**** Form MUST be completed prior to signing. You may refuse to sign this Authorization****

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Initial Adult Registration

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NOTICE: If you are uncomfortable completing certain sections, you can provide the information in person or by phone after submission of your signature. Fields in red are required before you can be scheduled.

Patient Name:____________________________________ **Date of Birth:** ____________ **Age:** ______

Last First Middle

Address:____

Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender: ☐ M ☐ F** ☐ ____

Phones: Home: ☐ ____________________ Work: ☐ ______________________ Cell: ☐ ___________________

Emails: Home: ☐ _______________________________ Work/Other: ☐ ________________________________

Preferred Contact (check ONE Phone and Email above)

Emergency Contact Name:	Relationship
Home Phone:	Cell Phone:

Primary Insurance:	Name of Insured	Secondary Insurance:
	Relationship to Patient	
Plan Type (PPO, HMO, etc):	Insured Date of Birth	Plan Type:
	Insured Occupation	
High Deductible: ☐ N ☐ Y ☐ ?	Employer	Group #
Group #	Employer Address	ID #
ID #		Plan Name
Plan Name:	Employer Contact name/phone:	

Referring Person/Practitioner Specialty (if applicable)	Primary Physician How many years under their care?:	Pharmacy Name: Address: Zip Code:
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:

Any Workman's Claim open within the last 5 years? ☐ No ☐ Yes	Status: ☐ Closed ☐ Open
Any Motor Vehicle Accident within the last 5 years? ☐ No ☐ Yes	Status: ☐ Closed ☐ Open
Is an attorney involved in any aspect of your care? ☐ No ☐ Yes	If yes, Name and role

Credit/Health **Card 1** Name:	Number:
Card Expiration:	Card Security #:
Credit/Health **Card 2** Name:	Number:
Card Expiration:	Card Security #:

I understand that the practice of medicine is not an exact science, and that the results cannot be anticipated. I acknowledge that no guarantees have or will be made to me as the result of examination, procedures or treatment. Before commencing treatment, I will be advised of the risks, benefits and alternatives to such treatment to my satisfaction.

The undersigned authorizes the release of medical information to healthcare providers, insurance companies, and/or regulatory agencies, which may be necessary for continuity of care and completion of doctor and hospital claims.

I hereby authorize payment directly to Wyndmoor Rehabilitation Associates, PC (“WRA”) of the physician insurance benefits otherwise payable to me for care rendered during the care provided. I understand that I am financially responsible for all charges not covered by my insurance. I agree to be assessed an interest fee of 1.5% per month for unpaid balances beginning at 30 days and a collection fee of 36% for payments past 60 days due.

If I cancel or no-show any visit with less than two full business days notice, I agree to be charged up to $250.00 as determined by the physician. I authorize WRA to charge the above credit card(s) for any unpaid balances and I will keep this information up to date. I am responsible for any legal costs required to collect unpaid balances.

I certify that I have submitted this document with complete and accurate information. I understand the agreements on this form, or will ask for and receive explanation before signing below. I will save a copy of this form for my records.

____ __________________________________
Patient Signature (or both parents/guardians if a minor) Date Witness Signature and Date

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Medical History
Page 1

Name:

Date:

Date of Birth:	Age	Height	Weight	Handed: R L

	LEAVE BLANK
How did you learn about our practice?	
Please describe the problem(s) that brought you here: (Attach additional pages if desired)	
When did THIS episode begin?	
How did THIS episode begin?	
If recurrent or intermittent, when did the FIRST episode begin?	
What is your theory (or "internet diagnosis") of how this developed (even if strange or rejected by others)	

What are your main goal(s) in seeking our services?

1)	
2)	
3)	
In what time frame do you wish to achieve your main goal(s)?	
What percentage improvement in your problem(s) will satisfy you?	
Do you have other priorities or limitations that so far have impeded your healing journey?	

PAST MEDICAL HISTORY	No	Yes	Describe	LEAVE BLANK
Do you have allergy to LATEX?				
... to any MEDICATIONS? (if yes, please list)				
... to any ENVIRONMENTAL AGENTS				

In the last 5 years have you…

	No	Yes	Describe	
…seen any OTHER PRACTITIONERS				
…had any INPATIENT SURGERY?				
…had any OUTPATIENT SURGERY?				
…had any HOSPITALIZATION(S)?				
…had any ER VISITS?				
…had any URGENT CARE VISITS?				

MOST RECENT TESTS:	Date	Reason	LEAVE BLANK
Blood Tests in the past year			
XRay			
CAT Scan			
Colonscopy/Endoscopy			
Dexascan (Bone Density Test)			
EKG			
EMG			
Mammogram/Prostate Exam			
MRI			
Stress Test			
Other:			

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Holistic Healing Readiness Survey

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Name:

Date:

	Strongly Disagree	Disagree	Neutral or Not Applicable	Agree	Strongly Agree
1) My current symptom(s) and/or problems are interfering with the quality of my life	☐	☐	☐	☐	☐
2) I am concerned about my future health and am willing to forgo some comforts and habits today to improve the quality of my life in the future	☐	☐	☐	☐	☐
3) I need to see some results within a few weeks or months to keep going with a treatment0	☐	☐	☐	☐	☐
4) I believe that I can heal at least 90% without drugs or surgery	☐	☐	☐	☐	☐
5) I am seeking holistic medical care because I am trying to avoid medications, surgery, or other conventional care	☐	☐	☐	☐	☐
6) I want to take control of my health and have already read about and tried "alternative medicine"	☐	☐	☐	☐	☐
7) My holistic doctor should be able to figure out my diagnosis and find medication(s) or supplement(s) to cure my problem(s)	☐	☐	☐	☐	☐
8) I can find 30-60 minutes per day to invest in my healing	☐	☐	☐	☐	☐
9) I am able and willing to invest $150-$500 per month for 4-12 months for a holistic program if it will allow me to heal at least 50%	☐	☐	☐	☐	☐
10) I am willing to eliminate some or all of my favorite foods, alcohol, soda and caffeine from my diet for at least three months	☐	☐	☐	☐	☐
11) I am willing to trial a regimen of supplements twice a day for three to six months to test the effect on my healing	☐	☐	☐	☐	☐
12) I am willing commit to at least 8 hours of sleep per night (or stay in bed 8 hours if I have a sleep problem)	☐	☐	☐	☐	☐
13) I am willing to go to a gentle yoga or other recommended movement class once per week for three to six months to test the effect on my healing	☐	☐	☐	☐	☐
14) I am willing to try a course of acupuncture, massage or other recommended body work for one to three months to test the effect on my healing	☐	☐	☐	☐	☐
15) My family and friends will support changes that will enable me to heal	☐	☐	☐	☐	☐
16) My employer and coworker(s) will support changes, including time off, that will enable me to heal	☐	☐	☐	☐	☐
17) I am willing to read educational materials if such knowledge will enable me to heal	☐	☐	☐	☐	☐
18) I am willing to explore the relationship between my mind and body, which might require psychotherapy, journaling and/or other psycho-spiritual work	☐	☐	☐	☐	☐

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PRACTICE POLICIES

Patient Name: ____________________

Dear Patient:

Welcome! We are glad to have the opportunity to work with you. Our mission is to provide high quality holistic medicine and physiatry while continuing to participate in several major insurance plans. This page will review our policies and procedures. Please see our website, cohlife.org for more information about Holistic Medicine and Physiatry.

1. **Clinical policies**

- You are welcome to have friends and family participate in your visits and other activities. If you wish for the physician to discuss your case without your presence, a special HIPAA form will need to be filled out beforehand.
- You are expected to maintain a relationship with a primary care physician "PCP" to handle routine medical issues such as medication renewals (for medications not prescribed or adjusted by me) vaccines, colds, and related conventional care. In addition, your PCP or other physician(s) may be needed to initiate or continue certain pharmaceuticals (such as blood pressure, diabetic, pain or thyroid medications) prescribed prior to or during your holistic medical treatment program.
- In holistic medicine, we work as a team with the physician, patient and staff all having certain responsibilities. Each visit will end with a written visit summary with specific tasks that you will be expected to complete prior to your next visit. Repeated visits without engagement in the process (i.e. reasonable completion of tasks) may be a cause for discharge from the holistic program.
- During office visits, let's be sure to renew prescriptions. There is fee for unreasonably urgent renewals between visits.
- You will be required to provide copies of any documents that are pertinent to your care or that you want Dr. Cheikin to review. COH staff cannot provide such copy services due to time constraints.
- Forms will be completed at our discretion. Some must be filled by your PCP or other practitioner(s).
- Nutriceutical supplements are provided in the same way as pharmaceuticals. We make our best effort to provide effective agents for your problems. We cannot guarantee results and cannot accept returns except for replacing clear manufacturing defects. Test doses are available for many agents.
- Many of our patients are very sensitive to chemicals. Please do not wear any commercial scents or lotions or previously-worn clothes that may contain such scents.

2. **Scheduling**

- Before beginning treatment, you will be informed about the recommended scope of treatment including the frequency of visits, lab tests and estimated costs to safely and effectively manage your holistic program. If you cannot attend visits or follow the prescribed protocols, the holistic program will be placed on hold or terminated.
- For most active programs, visits will be required at least every 3-4 months. Once your goals are met, "maintenance" status will require visits once or twice per year, to be mutually determined and documented in your visit note.
- We will schedule office visits for 30-45 minutes. If you need more time, we can schedule more frequent visits to cover your medical needs. You can also elect to pay privately if you want an extended visit, but this must be scheduled in advance.
- Lateness of more than 10 minutes will be treated as a partial no-show. If you are concerned about making appointments in advance, we will try to accommodate your needs if arranged in advance.
- **Because of the complex needs of our patients, we sometimes run late and cannot guarantee an exact start time. Please plan your appointment accordingly, including time for the important checkout after the visit with the physician. If you cannot work within this parameter, then we can discuss options during our first visit.**
- **If your insurance carrier requires a referral, it is your responsibility to make sure the referral is obtained from your primary care physician <u>before</u> the visit. You will be financially responsible for the office visit if a referral is not obtained. If an office visit is cancelled due to lack of referral, you will be charged a cancellation fee.**
- Cancellation fees and additional policies are specified in the Initial Registration document and related documents.

3. **Covered and Non-Covered Services**

a. Health plans usually cover <u>(but we do not represent or study your individual plan; see separate Health Insurance Policy)</u>**:**

- Initial office visits up to 60 minutes (only "face-to-face time" is covered; and you will need a referral at the time of visit if you have an HMO)
- Follow-up office visits between 15-40 minutes (same requirements as initial visit)
- Conventional lab tests and review during office visits
- Conventional medications and treatments prescribed by a physician if on the plan's formulary (and subject to the individual plan's entitlements & limits)
- Phone calls to other physicians and practitioners during office visits
- Counseling of patient
- Coordination of care with family members during office visits

b. **Your health insurance plan will <u>not</u> cover these fees** (but some may be charged to a Healthcare Savings Account (HSA)):

- Copays (due at time of visit) and Deductibles
- Office visits that go over time
- Holistic Services and access to proprietary web site materials that will be reviewed separately and for which there are separate fees that you will know of in advance.
- "Non-covered" lab tests and their Interpretation by the physician
- "Case Management" assistance with health carrier issues (such as coverage, referrals) and legal/administrative matters
- Phone and email communications with the patient if excessive or utilized in lieu of an office visit.
- Phone calls to other practitioners not during office visit time
- Review of tests and other information outside of the visit
- Copying costs as specified by statute
- Medical forms and letters that you provide for other agencies

Due to the ongoing malpractice and health insurance crisis in Pennsylvania, many holistic doctors have left the state and/or have stopped participating in insurance plans. Agreeing to these mutual commitments at the beginning of our relationship will allow us to make the most of our visits, and allow us to focus on providing you with the best quality we can. Thank you in advance for your understanding and cooperation. Please feel free to discuss any concerns you have about the above during our visit(s).

I have read, understand and agree to be bound by the above policies. I agree to save a copy for my records.

____ ______________
Patient's (or BOTH parent/guardian's) signature Date

Michael Cheikin M.D., Holistic Medicine & Physiatry

REQUEST & CONSENT FOR PARTICIPATION IN THE HOLISTIC MEDICINE PROGRAM

I, __________________________ consent and request to participate in the Holistic Medicine Program. Holistic Medicine is an art of healing involving the evaluation and treatment of the body, mind and spirit, using a program that is specifically tailored to re-establishing balance in the body. Modalities may include, but are not limited to, conventional (standard) diagnostic testing and treatment, special (non-covered) diagnostic testing, special diets, special supplements, herbs, acupuncture, yoga, energy medicine techniques, ayurvedic and Chinese medical treatments, mind-body techniques such as meditation, hypnosis, journaling, and breathing exercises.

I have been advised to discuss the risks and benefits of Holistic Medicine with my doctor(s) and other health care practitioner(s), especially if I have any questions about participation. I understand that I am expected to continue my usual medical care. I understand that the Holistic Medicine Program will not replace, substitute for, or provide the routine medical care that should be provided by my primary care physician and specialist physicians. I understand that I might be referred back to my primary care physician if the Holistic Medicine evaluation suggests an underlying medical condition that requires further conventional and/or urgent medical evaluation and treatment.

I understand that I have certain responsibilities in participating in the Holistic Medicine Program. These include, but are not limited to: providing a complete and honest history, following through on recommended tests and treatments, returning for follow-up visits as scheduled, abiding by the practice policies and procedures, recognizing the limits of my health insurance plan, and advising my other health care practitioners of my participation in this program.

Exclusions from certain Holistic Medicine modalities may include but are not limited to pregnancy, active chemotherapy and active treatment by another provider. I will inform Dr. Cheikin if any of these conditions exist. I am aware that Holistic Medicine may mask an underlying condition or delay a more exact diagnosis where conventional or standard therapy(ies) may be known to be indicated. While unlikely, I recognize that sickness or death could occur as a possible consequence of any therapy which alters function of the body, mind or spirit. I understand that it usually requires a series of treatments to significantly change my condition, but no guarantee of results has been made. The nature and consequences of the above treatment have been fully explained, and I am satisfied that participation in this Program is in my best interest. I understand that I may withdraw this consent at any time.

NOTICE OF NON-COVERAGE: Most (if not all) insurance companies (such as Medicare, PPO's, HMO's, etc.) will not cover some or all of the services that this Holistic Medicine Program provides. As such, I understand and agree to be personally and fully responsible for payment for such non-covered services, or the non-covered portion of such services. I understand that there are Holistic Membership and Program fees for services that are not covered, and that such fees cannot be submitted for reimbursement by my insurance carrier.

In consideration of my being able to participate in this program, I agree to release all liability and to indemnify Michael Cheikin MD, Wyndmoor Rehabilitation Associates PC ,and their respective affiliated companies, including the owners and operators of the facility in which these services will be provided, their officers, directors, shareholders, agents including independent contractors, employees, representatives and their successors and assigns, from and against all claims, actions, judgment, cost, expenses and demands with representatives and their successors and assigns, from and against all claims, actions, judgments, cost, expenses, and demand with respect to injury, loss, death or damage to my person or property in connection with my taking part in the above stated program. It is understood and agreed that this release is to be binding on myself, my heirs, executor, administrators and assigns.

I certify that I have read the above and understand it. Intending to be legally bound hereby, I make this agreement.

____ ________________________ f_holistic_consent_2021_05_17.docx

Name Date

Michael Cheikin MD
Holistic Medicine & Physiatry
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610-239-9901 www.cohlife.org

Lab Notices and Policies

5/17/2021

Name:

Date:

While we "accept" most insurance plans for medically necessary office visits, there can be confusion regarding coverage including laboratory studies. The following notices and policies apply:

1. It is your responsibility and entitlement to understand what your insurance plan covers and does not. You should review your policy with your carrier before accepting any services, whether medical, lab or other. Because of the huge numbers of insurance plans, we are unable to manage the specifics of your plan. There is no guarantee that any service will be covered by your carrier. Some plans require you to go to specific labs (i.e. Quest or LabCorp).

2. All the labs that Dr. Cheikin orders are "medically necessary and reasonable," which means that in his opinion as a licensed physician, he believes that the tests he orders will help diagnose and guide treatment for your problem(s). However, we have no say in your insurance carrier's policies regarding coverage, deductibles, co-pays, exclusions or what they deem to be "experimental". We will do our best to provide appropriate diagnostic and treatment codes to medically justify the services provided. This does not ensure coverage by your insurance. **You will have the opportunity to review your lab orders with your insurance carrier before doing any test.**

3. As best as we know, we will tell you in advance if any tests are not "covered" by your insurance plan. Non-covered tests usually include those for halides, toxins such as heavy metals and pesticides, and others. We will only order these tests with your advance consent and payment. Some of the "non-covered" lab costs, may be eligible for reimbursement if you have a HSA (Health Care Savings Account) or MSA (Medical Savings Account).

4. If you know that your carrier does not "cover" certain important labs (such as homocysteine by Aetna or MTHFR by the Blues) that are provided by conventional labs such as Quest or LabCorp, we can often perform the lab at a discount compared to what you might pay. In such cases, we must work out the details in advance.

6. **Fees for "non-covered" labs provided by our office, which include design and interpretation, are non-refundable**. You are required to complete any test kits within 30 days of receipt unless otherwise noted in your written visit note or plan.

7. There is a fee for the review, design, interpretation of a metabolic lab panels not provided within the scope of conventional practice. This fee also covers the design and support of a supplement protocol(s) that are based on such testing. We encourage labs in sets of two, since testing your individual response to a supplement or lifestyle protocol is the point of doing the tests in the first place. **No insurance company pays for interpretation of metabolic labs and design of supplement protocol(s) ordered within the scope of this holistic practice**.

8. **You are responsible for returning for an office visit within 3-4 weeks after having labs performed**, to interpret the labs and to adjust your program accordingly. We cannot send you copies of labs without review and interpretation, because of the medico-legal responsibility for acting upon these studies. For your safety, without review, labs will only be released to a physician who is assuming responsibility for you continued care (i.e. your primary care or other). You can get copies of many of your labs from portals provided by LabCorp, Quest and other labs.

9. The "reference ranges" provided by most labs are based on a "typical" American population and DO NOT represent "normal" or "healthy". I**t is potentially dangerous to self-interpret labs** that are within and outside of the reference range to self-diagnose without the participation of a licensed physician. We use proprietary parameters for the labs that are different from the "typical" values. The interpretation and design fees discussed above cover the cost of these proprietary protocols.

I have read and agree to be bound by the above policies. I understand that I can print a copy from the website).

____

Patient's (or both guardian's) signature Date

PAST MEDICAL AND FAMILY HISTORY **Michael Cheikin MD**

Last Name:	First Name:	Date of Birth:	Today's Date:

Please check if yes, circle if multiple choices provided	You	Father	Mother	Father's Family	Mother's Family	Brothers	Sisters	Spouse	Children	LEAVE BLANK
Age(s) (if living)										
Health G=good, B=bad										
Alcohol Overuse										
Allergies										
Alzheimer's/Dementia										
Anemia										
Arthritis (Osteo-)										
Asthma/COPD/Lung Issues										
Autism, ADHD, Aspergers										
Autoimmune Disease										
Bipolar or Schizophrenia										
Bleeding or Clotting Disorder										
Broken Bones: Patient only, age, location:										
Cancer/Leukemia										
Constipation/Colitis/Crohns										
Dementia/Alzheimers										
Depression/Anxiety/Panic										
Diabetes										
Eczema/Psoriasis										
Epilepsy/Seizures										
Fibromyalgia/Chronic Fatigue										
Gallbladder Disease										
Heartburn/GERD/Barretts										
Heart or Circulatory Disease										
Headaches/Migraines										
Hepatitis										
High Blood Pressure										
High Cholesterol										
Kidney Disease/Stones										
Irritable Bowel (IBS) or Bladder										
Liver/Gallbladder Disease										
Lung Disease/Emphysema										
Lupus										
Multiple Sclerosis										
Obesity										
Pain Syndrome (Neck, Back, etc)										
Polycystic Ovarian Syndrome										
Prior Work/Auto Injury, Patient only, dates:										
Psychiatric Illness/Suicide										
Raynauds										
Rheumatoid Arthritis										
Root Canals, Patient only, dates:										
Sinusitis/Ear Infections										
Stomach Ulcers/Reflux										
Street Drug Use (Pot, Cocaine, etc)										
Stroke										
Scoliosis										
Smoke (now or past)										
Thyroid Disease/Goiter/Graves										
Toxic Exposure										
Urinary Tract Infections										
Yeast Infection(s)										
Infections within the last five years requiring treatment (patient only,list:)										
Other Important Conditions: list: (use back for more)										
Age(s) at death										
Cause(s) of Death more)								[ ] more on back		

PLEASE LEAVE BLANK f_outpatient_hx_pmh_fmhx.r26.docx

Name: Date:

(symptoms within the past 12 months; "in past' = > 12 months ago)		Never	In past	Mild/ Occ	Moderate /Regular	Severe/ Frequent	Please describe	**PLEASE LEAVE BLANK**
Const	Not feeling well							
	Weight loss							
	Weight gain							
	Low body temperature							
	Fevers							
	Fatigue							
	Night sweats							
Psych	Anxiety							
	Irritability							
	Panic							
	Depression							
Musc-Skel	Joint pain							
	Joint heat or swelling							
	Weakness							
	Muscle pains/spasms							
Neuro	Numbness							
	Tingling							
	Poor Memory/Concentration							
	Falls							
	Fainting							
	Headache							
ADL's	Difficulty with Buttons/Laces							
	Difficulty Climbing Stairs							
	Difficulty Walking							
	Difficulty Lifting							
	Difficulty Changing Position							
	Difficulty Driving							
Heme	Bruising							
	Bleeding							
	Calf Tenderness							
Eyes	Blurred vision							
	Double vision							
	"Floaters"							
	Dry Eyes							
ENT	Sore throat							
	Difficulty Swallowing							
	Dizzyness							
	TMJ							
	Dental Work							
	Silver (Amalgum) Fillings Removed							
Cardiac	Chest Pain							
	Palpitations							
	Shortness of Breath with Exertion							
	Shortness of Breath at rest							
Vasc	Swelling in Extremities							
	Calf Tenderness							
	Swollen veins							
	Cold/Hot/Red/Blue Extremities							
Resp	Cough							
	Chest Tight/ Difficult Catching Breath							
	Wheezes							
GU	Urgency to void urine							
	Difficulty voiding							
	Losing urine (cough, sneeze, etc.)							
Immun	Enlarged lymph nodes							
	Yeast/Fungal infection(s)							
	Cold sores/Herpes mouth / genitals							
	Easily get colds or sinus infection							
	Other infections (please list)							

REVIEW OF SYMPTOMS, Page 2 of 2

Name: Date:

(symptoms within the past 12 months)		Never	In past	Mild/ Occ	Moderate /Regular	Severe/ Frequent	Please describe	**PLEASE LEAVE BLANK**
Sleep	Problems falling asleep							
	Problems staying asleep							
	Early awakening							
	Snoring							
	Restlessness							
	Not refreshed in am							
	Daytime sleepyness							
	Need/takes naps							
	Average # hours/night							
GI	Pain							
	Bad Breath							
	Burping							
	Heartburn							
	Problems Swallowing							
	Reflux/repeating (list foods)							
	Nausea/Vomiting							
	Bloating after meals							
	Gas/Flatulence							
	Constipation							
	Diarrhea							
	Hemorrhoids							
	Itchy Anus							
	Stools float/Yellow stools							
	Blood in Stools/Stools Black							
Endo	Heat/Cold Intolerance							
	Frequent thirst							
	Frequent hunger							
	Irritable/shaky when hungry							
	Frequent urination							
	Loss of height							
	Grey Hair (age first noticed)							
	Decreased libido							
Skin	Rashes							
	Dry							
	Itchy							
	Hair Loss							
	Fragile Nails							
	Yellow/thick nails							
	Other lesions							
Women	Fibrocystic breasts							
	Periods irregular/stopped							
	PMS							
	Increased hair							
	Acne							
	Hot flashes							
	Age periods started/ended							
	Days of cycle/period (i.e. 28/4)							
	# of pregnancies/miscarriages							
	Pill/Hormones (list ages)							
Men	Frequent Urination							
	Waking to Urinate							
	Erectile Dysfunction							
	Other (Pain):							
Other Strange or Recurrent Symptoms, even if dismissed by other doctors: Please describe on back of page: symptom, location in body, how often, how severe, what makes it better or worse.							☐ see back	

PLEASE LEAVE BLANK (Complete >= 10, Extended 2-9, Brief 1)	
☐ Without interval change from ROS obtained (give date):	☐ All other systems negative
☐ Unable to obtain from patient due to	Signature

MEDICATIONS AND SUPPLEMENTS

M Cheikin MD

Name:	Date:

List CURRENT medications and supplements you are taking on a regular or intermittent basis

Medication/ Supplement	Date Started (Approx)	Purpose	Dose and Frequency	Effectiveness	Side Effects	Leave Blank

☐ Continued on Back

List DISCONTINUED medications and supplements you have taken over the past 2 years

Medication/ Supplement	Date Started (Approx)	Date Stopped	Reason for Stopping	Side Effects	Leave Blank

☐ Continued on Back