BREAKTHROUGH MEDICINE

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Please check box if Contact Information has changed:

RETURN VISIT UPDATE FORM

Today's Date:

PATIENT INFORMATION UPDATE

Last name: First: Middle:

Address: Phone:

Occupation: Employer: Employer Phone:

REASON FOR VISIT

List reason for visit: (e.g. chest cold, pain, prescription renewal, lab review, drug side effect, detox inquiry, specialist referral needed, annual checkup, etc. Please place in order of importance.

1.	2.
3.	4.
5.	6.
7.	8.

Please list prescriptions you may need refilled (by name):

List all Labs, Reports, Bloodwork, Thermal, Mammograms, Bone Density, X-Rays, Hair Analysis, Stool Testing, etc.

Any change in your health since your last visit? Choose:	If "Yes" please explain below:
This could be a new condition: Major life change (divorce, death in family, new job, etc.)	
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Have you see another medical provider, had a medical procedure, gone to urgent care, the emergency room or been hospitalized since our last visit? Choose:	If "yes" list provider's name, medical facility, and reason?
1.	2.
3.	4.
5.	6.
7.	8.

Please list all current medications dosages, and how you are taking your medication. Please note any changes since your last visit such as side effects and having to stop medication or reducing dose.	
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

List what you're really taking in supplements, doses, and how you are taking (such as once daily, twice daily or at bedtime:	
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.
13.	14.

HEALTH PROFILE

NAME _____ DATE _____

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

Point Scale	0	***Never*** or ***Almost never*** have the symptom	3	***Frequently*** have it, effect is ***not severe***
	1	***Occasionally*** have it, effect is ***not severe***	4	***Frequently*** have it, effect is ***severe***
	2	***Occasionally*** have it, effect is ***severe***		

HEAD	____	HEADACHES
	____	FAINTNESS
	____	DIZZINESS
	____	INSOMNIA
	____	**TOTAL**
EYES	____	WATERY OR ITCHY EYES
	____	SWOLLEN, REDDENED OR STICKY EYELIDS
	____	BAGS OR DARK CIRCLES UNDER EYES
	____	BLURRED OR TUNNEL VISION (Does not include near or far-sightedness)
	____	**TOTAL**
EARS	____	ITCHY EARS
	____	EARACHES, EAR INFECTIONS
	____	DRAINAGE FROM EAR
	____	RINGING IN EARS, HEARING LOSS
	____	**TOTAL**
NOSE	____	STUFFY NOSE
	____	SINUS PROBLEMS
	____	HAY FEVER
	____	SNEEZING ATTACKS
	____	EXCESSIVE MUCOUS FORMATION
	____	**TOTAL**
MOUTH/ THROAT	____	CHRONIC COUGHING
	____	GAGGING, FREQ. NEED TO CLEAR THROAT
	____	SORE THROAT, HOARSENESS, LOSS OF VOICE
	____	SWOLLEN OR DISCOLORED TONGUE, GUMS, LIPS
	____	CANKER SORES
	____	**TOTAL**
SKIN	____	ACNE
	____	HIVES, RASHES, DRY SKIN
	____	HAIR LOSS
	____	FLUSHING, HOT FLASHES
	____	EXCESSIVE SWEATING
	____	**TOTAL**
HEART	____	IRREGULAR OR SKIPPED HEART BEAT
	____	RAPID OR POUNDING HEARTBEAT
	____	CHEST PAIN
	____	**TOTAL**
LUNGS	____	CHEST CONGESTION
	____	ASTHMA, BRONCHITIS
	____	SHORTNESS OF BREATH
	____	DIFFICULTY BREATHING
	____	**TOTAL**

DIGESTIVE TRACT	____	NAUSEA, VOMITING
	____	DIARRHEA
	____	CONSTIPATION
	____	BLOATED FEELING
	____	BELCHING, PASSING GAS
	____	HEARTBURN
	____	INTESTINAL / STOMACH PAIN
	____	**TOTAL**
JOINTS/ MUSCLES	____	PAIN OR ACHES IN JOINTS
	____	ARTHRITIS
	____	STIFFNESS OR LIMITATION OF MOVEMEMENT
	____	PAIN OR ACHES IN MUSCLES
	____	FEELING OF WEAKNESS OR TIREDNESS
	____	**TOTAL**
WEIGHT	____	BINGE EATING/DRINKING
	____	CRAVING CERTAIN FOODS
	____	EXCESSIVE WEIGHT
	____	COMPULSIVE EATING
	____	WATER RETENTION
	____	UNDERWEIGHT
	____	**TOTAL**
ENERGY/ ACTIVITY	____	FATIGUE, SLUGGISHNESS
	____	APATHY, LETHARGY
	____	HYPERACTIVITY
	____	RESTLESSNESS
	____	**TOTAL**
MIND	____	POOR MEMORY
	____	CONFUSION, POOR COMPREHENSION
	____	POOR CONCENTRATION
	____	POOR PHYSICAL COORDINATION
	____	DIFFICULTY IN MAKING DECISIONS
	____	STUTTERING OR STAMMERING
	____	SLURRED SPEECH
	____	LEARNING DISABILITIES
	____	**TOTAL**
EMOTIONS	____	MOOD SWINGS
	____	ANXIETY, FEAR, NERVOUSNESS
	____	ANGER, IRRITABILITY, AGGRESSIVENESS
	____	DEPRESSION
	____	**TOTAL**
OTHER	____	FREQUENT ILLNESS
	____	FREQUENT OR URGENT URINATION
	____	GENITAL ITCH OR DISCHARGE
	____	**TOTAL**

GRAND TOTAL ____

FEMALE HORMONE SURVEY

NAME: _____ DATE: _____

Please score: BLANK= No Symptoms. 1-5 (1=Mild 5=Severe)

Hot Flashes	_____
Night Sweats	_____
Irritability	_____
Mood Swings	_____
Weepy	_____
Irregular Periods	_____
Heavy Periods	_____
Bleeding between periods	_____
Low sex drive	_____
Lumpy breasts	_____
Unable to reach orgasm	_____
Painful intercourse	_____
Lack of vaginal lubrication	_____
Breast tenderness	_____
Drooping breasts	_____
Sleep problems	_____
Anxiety or panic attacks	_____
Depression	_____
Loss of motivation	_____
Feeling apathetic	_____
Fatigue	_____
Memory loss	_____
Thinning hair	_____
Dry skin	_____
Cellulite	_____
Decreased muscle strength	_____
Fluid retention	_____
Headache	_____
Joint pain	_____
Muscle pain	_____
Urinary incontinence	_____
Acne	_____
Facial hair growth	_____
Constipation	_____
Food Cravings	_____
Vaginal Discharge	_____
Vaginal Itching	_____
TOTAL	_____