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BREAKTHROUGH MEDICINE
 SHAIDA SINA, NMD

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 MOVEMENT

_____ PAIN OR ACHES IN MUSCLES

_____ FEELING OF WEAKNESS OR TIREDNESS

_____ **TOTAL**

WEIGHT

_____ BINGE EATING/DRINKING

_____ CRAVING CERTAIN FOODS

_____ EXCESSIVE WEIGHT

_____ COMPULSIVE EATING

_____ WATER RETENTION

_____ UNDERWEIGHT

_____ **TOTAL**

**ENERGY/
ACTIVITY**

_____ FATIGUE, SLUGGISHNESS

_____ APATHY, LETHARGY

_____ HYPERACTIVITY

_____ RESTLESSNESS

_____ **TOTAL**

MIND

_____ POOR MEMORY

_____ CONFUSION, POOR COMPREHENSION

_____ POOR CONCENTRATION

_____ POOR PHYSICAL COORDINATION

_____ DIFFICULTY IN MAKING DECISIONS

_____ STUTTERING OR STAMMERING

_____ SLURRED SPEECH

_____ LEARNING DISABILITIES

_____ **TOTAL**

EMOTIONS

_____ MOOD SWINGS

_____ ANXIETY, FEAR, NERVOUSNESS

_____ ANGER, IRRITABILITY, AGGRESSIVENESS

_____ DEPRESSION

_____ **TOTAL**

OTHER

_____ FREQUENT ILLNESS

_____ FREQUENT OR URGENT URINATION

_____ GENITAL ITCH OR DISCHARGE

_____ **TOTAL**

GRAND TOTAL

TOTAL

MALE HORMONE SURVEY

NAME _____

DATE _____

Please score: BLANK= No Symptoms. 1-5 (1=Mild 5=Severe) Place your mouse on the line and type your numeral.

- Constipation _____
- Muscle pain _____
- Joint pain _____
- Low sex drive _____
- Erectile firmness _____
- Erectile stamina _____
- Decreased ejaculate _____
- Unable to climax _____
- Premature climax _____
- Fatigue _____
- Loss of motivation _____
- Decreased strength _____
- Decreased endurance _____
- Depression _____
- Anxiety _____
- Mood swings _____
- Foggy thinking _____
- Adult acne _____
- Difficulty passing urine _____
- Pain with passing urine _____
- Dry skin _____
- Thinning hair _____
- Anger/ Irritability _____
- Breast enlargement _____
- Increase in abdomen girth _____
- Insomnia _____
- Weight gain _____
- Rapid weight loss _____
- Over sensitive/ weepy _____
- Thinning of skin _____
- TOTAL** _____