

Information for the Physician

1. All medications, vitamins and health care preparations you are using for any reason.

Medication	Dosage	When and How Used
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. A medical history of yourself and your family:

Your history

Mother's side of the Family

Father's side of the Family

3. Describe changes in:

appetite or diet _____

weight _____

sleep patterns _____

sexual interest _____

ability to concentrate _____

memory

Have you recently had:

_____ headaches (describe)

_____ numbness or tingling anywhere (where?)

_____ loss of balance (describe)

_____ double vision or vision problems (describe)

_____ periods of amnesia (describe)

_____ coordination changes (describe)

_____ weakness in arms or legs (describe)

____ fever (describe)

____ nausea or diarrhea (describe)

____ other gastrointestinal problems (describe)

____ fainting or dizziness (describe)

____ seizures (describe)

____ stressful life events (describe)

Add additional sheets for other pertinent information.