

Information for the Physician

Date:

Name:

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 you 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

Information for the Physician [con't]

Name:

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.