Linda J. Melos, ND

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Welcome to my practice as a new patient! I am honored that you selected me as your partner in natural health care. Please complete the following forms and bring them to your first visit.

If you wish to cancel or reschedule your appointment, please notify our office at least 24 hours in advance.

Because of my chemically sensitive patients, please refrain from wearing scented hair sprays, colognes, perfumes, aftershaves, etc. on the day you are here.

Date:

Name: Birth date:

Mailing Address:

(Street or PO) (City) (State) (Zip)

Telephone:Hm Wk

Cell: email:

Employed by: Occupation:

Referred by: Emergency contact:

Case History

List the main problems that you are having, or reason for this appointment:

Past Medical History

Major Illness:

Accidents or major trauma (Scars – Please give location):

Hospitalizations/Surgeries (Please give month/year if possible):

Dental Procedures (root, canals, etc.):

Current Prescription Medications (Name and doses):

Allergies and Sensitivities: Foods, Environmental, etc. (Ever Tested ? (copies of reports)):

Occupational Exposures:

Vaccinations:

- ☐ DPT (Diphtheria, Pertussis, Tetanus)
- ☐ Booster (Usually DT)
- ☐ Polio Injection ☐ Polio Oral
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ HBV (Hepatitis B Vaccine)
- ☐ Other (Flu? Shots? etc.)

Marital Status:

Women:

Last Pap: Previous Infections? Last Menstrual Period:

No. of Pregnancies: Deliveries: Complications?

Use of Contraceptive?(type/dose): Hormone Replacement Therapy?(type/dose):

Lifestyle Factors (Please fill in the approximate amounts and frequency for each):

Coffee:

Tobacco:

Alcohol (type):

Recreational Drugs:

Exercise Activities (length of time and frequency for each):

Walk:

Run:

Swim:

Dance:

Bike:

Garden:

Golf:

Tennis:

Ski (type):

Weights:

Others:

Supplements Intake

Please fill in this form with any vitamin, mineral, amino acid, or other supplements or medication that you may be taking.

Supplements	Manufacturer	Form	Dosages	Frequency
Example:				
Vitamin C	Bronson	Tablet	500mg	2 Per Day
Comments:				

Diet Log

Please write down everything you eat and drink for 3 typical days. This includes all beverages and estimated amount of daily water intake. If you are following any particular diet plan, please indicate that at the bottom of this sheet.

	Day 1	*Day 2*	*Day 3*
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snacks			

Family Medical History

Please give age, list of any illness or if deceased; if deceased, list cause of death and age of death.

Mother:

Father

Brothers and Sisters:

Mother's Parents:

Father's Parents:

Possibilities

Allergies
Alcoholism
Asthma
Bleeding Tendency
Cancer-Type
Crohn's Disease
Diabetes-Age at Onset
Drug Abuse
Epilepsy
Gall Bladder
Glaucoma
Heart Disease-Type
High Blood Pressure
Hearing Loss
Hypoglycemia
Kidney Disease
Liver Disease-Type
Lupus
Mental Illness-Type
Multiple Sclerosis
Rheumatoid Arthritis
Thyroid Disease
Tuberculosis
Skin Disease-Type
Other Conditions