Linda 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 hairsprays, colognes, perfumes, aftershaves, etc. on the day you are here.

Date_____

Name_____ Birthdate_____

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:

_____
_____
_____
_____
_____

Please attach additional page if necessary

Past Medical History

Major Illnesses:

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

Dental Procedures (root canals, etc.):

_____
_____
_____

Current Prescription Medications (names 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.)

Women: Last Pap_____Previous infections?_____Last menstrual period_____
Marital History_____No. of Pregnancies_____ Deliveries_____ Complications?_____
Use of Contraceptive? (type/dose)_____ HRT? (type/dose)_____

Lifestyle Factors (Please fill in the approximate amounts):

	Never	Occasionally	Weekly	Daily
Coffee				
Tobacco				
Alcohol (type)				
Recreational drugs				

Exercise Activities

	Never	Minutes	Hours	Weekly	Daily
Walk					
Run					
Swim					
Dance					
Bike					
Garden					
Golf					
Tennis					
Ski (type)					
Weights					
Other					

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	Dosage	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			
Snack			

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
Chron'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