Carolyn Coker Ross, MD, MPH
Eating Disorder and Integrative Medicine Consultant

MR #_____

Name	Appointment Date	Appointment Time

✎✎✎✂***Please attach medical records as appropriate.*** **Contact #** _____

Concern (Please rank by priority) Example: Headaches	Onset June 1978	Frequency 4 times/wk	Severity mild/mod/severe
1.			
2.			
3.			
4.			
5.			
6.			

What are your goals for this visit?

Illnesses

	Past	Present	List family members who have had these illnesses (siblings, parent, grandparent, children)
Heart Disease	✎	✎	
Hypertension	✎	✎	
Cancer	✎	✎	
Diabetes	✎	✎	
Lung Disease (asthma, etc.)	✎	✎	
Hepatitis	✎	✎	
Digestive	✎	✎	
Seizures	✎	✎	
Thyroid Disease	✎	✎	
Other _____	✎	✎	
Other _____	✎	✎	
Other _____	✎	✎	
Other _____	✎	✎	