

Carolyn Coker Ross, MD, MPH

Eating Disorder and Integrative Medicine Consultant

MR # _____

Name	Appointment Date	Appointment Time
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 **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 _____  

Allergic reaction to medications

Medication

Reaction/Intolerances

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Operations

Injuries

What	When	What	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments

Occupation

What interests/hobbies do you have?

With whom do you live? (Include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Patient Name _____

MRN _____

What physical activity do you participate in?

What are the major stressors in your life?

What do you do to relax?

Religious affiliation, past and present

What prior experiences have you had with alternative medicine?

Tobacco

- Never used Smoked from age ____ to ____. ____ packs per day.

Alcohol

- Never used Estimated drinks per day ____.

Other Drugs

- Never used Frequency ____.

What medications are you taking now? (Include prescription and over-the-counter drugs.)

Medication	Reason	When Started	Dosage Per Day	Cost
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Patient Name _____

MRN _____

2. How many servings of fruit do you eat/drink each day?

(Serving = 1 small piece fruit, 1/2 cup juice, 1/2 cup canned or chopped fruit, 1/4 cup dried fruit)

3. How many servings of vegetables do you consume each day? (Serving = 1/2 cup raw or cooked vegetables, 1 cup fresh, green leafy vegetables, 1/4 cup dried vegetables, or 1 small piece)

4. Are you currently on a special diet? If so, please describe:

5. What type of oil or spreads do you add to your food? _____

6. What do you drink on a typical day? _____

7. How would you describe your relationship with food? _____

Patient Name _____

MRN _____

