Information for the Physician

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 yourself 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

____

____

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.