PROGRESS REPORT

DATE: _____PATIENT'S NAME: _____ DOB: _____

MOBILE PHONE NUMBER: ( ) _____ HOME PHONE NUMBER: ( ) _____

Your Email Address: **(please write legibly in UPPERCASE)** _____ @ _____
If needed, may we E-mail information, recommendations, or your lab results at this E-mail address? Yes No (encircle)

1 .Tell us about your successes with treatment, i.e., the symptoms that have improved:

2. Be a good story-teller: What problems you want to solve or talk about? **What are your major symptoms and problems that you want to get rid of?** Please explain. In describing your symptoms, think of duration, i.e., how long you have been having it, how severe it is, and its frequency (how often you experience it) and do you have a clue what may be **causing or aggravating** these problems?

3. What seems to aggravate the above symptoms if any, and what seems to relieve them. Are there any other symptoms that you experience along with them? Please explain:

4. Overall, the treatment has helped me feel better (circle one): 25% 50% 75% 90% 100% No change

5. What medicines are you currently taking?

6. ROS

Check below if any of the following symptoms are bothersome (✓)

1. ENT	❑Nasal congestion; ❑Stopped up nose; ❑Runny nose; ❑Sneezing; ❑Post-nasal drip; ❑Sinus infections; ❑Sinus pain; ❑Hay fever; ❑Ear ache; ❑Feeling fluid in ears
2. Pulmonary	❑Coughing; ❑Chest congestion; ❑Chest tightness; ❑Wheezing; ❑ Difficulty breathing; ❑ Heaviness in chest; ❑ Shortness of breath on exertion
3. Throat	❑Sore throat; ❑Difficulty swallowing; ❑Canker sores
4. Eyes	❑Watering of eyes; ❑Itching of eyes; ❑redness of eyes; ❑Dark circles under the eyes;
5. Digestive	❑Diarrhea; ❑Constipation; ❑Gas; ❑Belching; ❑Bloating; ❑Heartburn; ❑ Indigestion; ❑Abdominal pain; ❑Coated tongue; ❑Hungry a lot; ❑Thirsty a lot; ❑Blood in stool;
6. Psycho/Neuro	❑Headaches; ❑Sadness; ❑Anxiety; ❑Nervousness; ❑Panic Attacks; ❑Irritability; ❑Poor memory; ❑Poor concentration; ❑ Mood Swings; ❑Can't Think Clearly; ❑Hyperactivity; ❑Insomnia; ❑Dizziness;
7. Energy	❑Fatigue; ❑ Wake up tired; ❑Unduly tired by the end of the day
8. Skin	❑ Cold hands; ❑Cold feet; ❑Dry skin; ❑Acne; ❑Hives; ❑Skin rashes
9. Musculo-Skeletal	❑Muscle pain; ❑Joint pain; ❑Muscle cramps; ❑Neck pain/spasm; ❑Lower back pain/spasm ❑Upper back pain/spasm
10. Cardio-vascular	❑High blood pressure; ❑Low blood pressure; ❑Rapid heartbeat; Palpitations; ❑Irregular/skipped heartbeat; ❑ Chest pain
11. Urinary	❑ Frequent urination; ❑Burning urination; ❑Awaken at night to urinate; ❑Urinate a lot;
12.Women	❑Vaginal discharge; ❑Premenstrual symptoms; ❑Changes in menstrual cycle; ❑Vaginal dryness; ❑Hot flashes; ❑Night sweats; ❑ Reduced libido; ❑Soreness of breast; ❑Lump, breast; ❑ Reduced libido
13. MEN	❑ Reduced libido ❑ Erectile dysfunction ❑ Frequent urination ❑ Awakens at night to urinate

PLEASE TURN THE PAGE OVER

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7. Since your last visit, has there been a change in your insurance, home telephone number, cell phone number or address?
No Yes

If yes, please give new information:

8. __ Since your last visit, has there been any change in your family history, health of any family member, occupation, drug use, marital status, tobacco use, alcohol use, occupational exposures (exposure to tobacco smoke, fumes, dust, solvents, airborne particles, noise)? Yes No
If yes, explain:

9. __Since your last visit, have you seen another physician? Yes No
If yes, explain:

10. **Basic Preventive Care**: which of the following you **did not** have in the last one year: A. Flu vaccine; B. Cholesterol check; C. Stool for occult blood (for colon cancer screen); D. Mammogram (Women); E.. Pap smear (Women) ; F. PSA (Men);

Encircle above that you did not have in the last one year.

❑ Check here if you are up-to-date on the above preventive care. Please Note: This is the recommended Preventive Care and we recommend it to you if you are over the age of 40.

❑, please check here if you would like to discuss some of this preventive care with us

When did you have Pneumovax (pneumonia vaccination) (age50&over)_____ H. Colonoscopy (age 50& over)_____.