DR. PATTY POWERS MD

WHOLE HEALTH CATALYSTS, P.C.

Dear Patient,

Welcome! And thank you for considering me as one of your health care providers.

New patient documents: Enclosed is a questionnaire I am asking you to fill out and return to me (by mail, fax or in person). If you have any medical records or lab reports from the last 2 years or so, or that pertain to the reasons I will be meeting with you, I would appreciate the opportunity to review these before our appointment. You can mail or fax them to us, or bring them by in person.

Deposit: As soon as we receive this, we will schedule you for a consultation with me. My staff will bill your credit card for a $300.00 deposit, which will be applied to your bill for your first appointment. If you do not have a credit card, then please mail us a check for $300, payable to Patricia Powers. Upon receipt of the check, we will contact you to schedule. If you need to reschedule an appointment, a minimum of 24 hours is required.

If you do not reschedule or cancel your appointment at least 24 hours in advance, then the $300 deposit will not be refunded, and will be considered a "no show" fee.

When we meet: Please bring your supplements with you! I will review your history, do a physical exam, and make recommendations for lab tests that will be appropriate for your specific health issues. Lifestyle and diet changes are key components to your health, and we will arrange for you to have some one-on-one help and guidance with making these changes.

After you have completed your lab tests, I will schedule an appointment with you to review your results and explain what they mean. I will create an individualized therapeutic program for you, which includes medication if needed, diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

Subsequent consults are scheduled to monitor your progress.

Payment will be due at the end of the appointment, by cash, check or credit card.

Contact us: I invite you to contact us by email via our secure Patient Portal, or by phone should you have any questions during the course of your treatment. To access the Portal, at your first visit, ask one of our staff to email you an invitation to sign up.

I use my Face Book page https://www.facebook.com/pages/Patty-Powers-MD/457560211067399 to announce educational events, workshops and group programs. I encourage you to Like my page and stay informed.

Website: www.drpattypowers.com

Location: I am located in the terrace (lower) level of Medical Associates of Central Virginia. The entrance is in the back of the building. Office hours are Monday through Friday, 8AM – 5 PM. I am usually in the office on Mondays and Thursdays.

As of September 1, 2015, I established my own Professional Corporation, separate from Medical Associates of Central Virginia. Although I still maintain my office at Medical Associates, we are separate businesses.

I look forward to assisting you in achieving your current health and wellness goals, and to guiding you in maintaining wellness throughout your life.

In health,

Patty Powers, MD and our Staff

Patricia Powers, MD
Whole Health Catalysts, P.C.
2215 Landover Pl
Lynchburg, VA 24501
434-947-5220 fax 434-544-2337

Patient's Name: _____ Today's Date:_____

Date of Birth:_____ Patient's Age_____

Address:_____

City: _____State_____Zip_____

Home Phone_____Work Phone_____Cell_____

Email:_____

I do / do not (please circle your choice) permit Dr. Powers to add me to her newsletter email list. Initials_____

Sex: M F Status: Pediatric Single Married Widowed Divorced # children_____

Occupation:_____ Employer_____Yrs Employed_____

Spouse's Name_____Occupation_____Employer_____

How did you find out about me?_____

If you are now being treated by another physician or physical or mental health practitioner, please describe each problem and write the name of the physician, health practitioner or medical facility treating you.

Are there any doctors that you would like to receive copies of these records? (If so, please include phone & fax numbers)

I authorize Dr. Powers to disclose my medical records to the above named health care providers.

Signature:_____Date:_____

Name:_____ relationship to patient:_____

Best way to contact you: home phone work phone cell phone

Circle which phone(s) I may leave messages on: home phone work phone cell phone

What are your top 3 medical issues / problems?

What are you hoping I can help you achieve?

Please provide history for each major problem. Begin with the onset of each problem and indicate doctors' visits, doctors' names, diagnoses, procedures, and results, and whether they were effective or ineffective.
(Some people find it helpful to create a timeline of events in their past. Please feel free to use more paper if you need.)

First Problem/diagnosis (specify):

When did this problem begin? What symptoms were present? What was going on in your life around that time?

Was there pain? [ ]Yes [ ]No Where?

How much pain? (on scale of 1 to 10 – circle please) 1 2 3 4 5 6 7 8 9 10

Describe the course or progression of this problem.

Did anything make problem better? Did anything make it worse?

What tests/procedures were done?

When were they done?

Where were they done?

Were you hospitalized for this condition? [ ]Yes [ ]No Where?

If yes, when were you hospitalized, and for how long?

What has happened to the problem since treatment until today?

What medications or supplements are you taking for this condition?

Second Problem/diagnosis (specify):

When did the problem begin? What symptoms were present? What was going on in your life around that time?

Was there pain? [ ]Yes [ ]No Where?

How much pain? (on scale of 1 to 10 – circle please) 1 2 3 4 5 6 7 8 9 10

Describe the course or progression of this problem.

Did anything make problem better? Did anything make it worse?

What tests/procedures were done?

When were they done?

Where were they done?

Were you hospitalized for this condition? [ ]Yes [ ]No Where?

If yes, when were you hospitalized, and for how long?

What has happened to the problem since treatment until today?

What medications or supplements are you taking for this condition?

Third Problem/diagnosis (specify):

When did the problem begin? What symptoms were present? What was going on in your life around that time?

Was there pain? [ ]Yes [ ]No Where?

How much pain? (on scale of 1 to 10 – circle please) 1 2 3 4 5 6 7 8 9 10

Describe the course or progression of this problem.

Did anything make problem better? Did anything make it worse?

What tests/procedures were done?

When were they done?

Where were they done?

Were you hospitalized for this condition? [ ]Yes [ ]No Where?

If yes, when were you hospitalized, and for how long?

What has happened to the problem since treatment until today?

What medications or supplements are you taking for this condition?

If you have any additional problems or diagnoses, please continue on a separate sheet of paper.

Please list any other current and ongoing health problems (include ADHD, anxiety, depression, asthma, recurrent ear or strep infections, etc):

Please circle the problem and note the year(s) if any of these have **EVER** been problems in your past:

Diabetes	Hepatitis	Arthritis	Infertility	ADHD
Hypertension	Jaundice	Osteopenia	Menstrual irregularities	Depression
High cholesterol	Gall bladder disease	Osteoporosis	Endometriosis	Anxiety/panic attacks
Heart disease	Inflammatory bowel disease	Thyroid problems	Uterine fibroids	Bipolar
Heart attack	IBS	Hypoglycemia	Fibrocystic breasts	OCD
Stroke/TIA	Food allergies	Seizures	Vaginitis	Asthma
HIV/AIDS	Kidney disease	Meningitis	PCO	Lung disease
Muscle disease	Urinary infections	Headaches	Eczema	Mold illness
Cancer (what type?)	prostatitis	Insomnia/sleep disorder	Hives	Lyme/tick disease
Anemia	Recurrent ear infections	Recurrent strep	Parasites	

Anything not already mentioned?

Your early years

Did your mother have any trouble with her pregnancy with you? Yes No Describe:
Were you born at [ ]full term? [ ] premature? How many weeks gestation?
Were there any problems with delivery? Yes No Describe: Were there any problems in the first week after delivery? Yes No Describe:
Did you have any health problems in the first year? Yes No Describe:
Did you have any health problems in your preschool years? Yes No Describe:
Did you have any health problems in your school years? Yes No Describe:

Have you had any genetic testing? If so, what did it show?

Hospitalizations/surgeries: List all times (and reasons) you have been hospitalized, operated on, or severely injured.

Date	Hospital admissions, procedures (what & why) for all illnesses, injuries	Doctor & Medical Facility

Allergies: Please list all allergies (medications, foods, pollen, animals, etc.) and the reaction(s) to each:

Immunizations: Up to date Delayed If delayed, why?

Any problems from immunizations? Yes No Describe:

Lifestyle

Who is living in household? _____
Any smokers in the home? Yes No
Do you smoke? Yes No amount/day_____ Vape? Yes No Did you smoke in the past? Yes No
How many years?_____ When did you quit?_____
Have you ever used marijuana? Yes No
Do you use chewing tobacco? Yes No
Do you drink alcohol? Yes No How many drinks/week?_____
Do you use recreational drugs? Yes No What kind?_____
How many years?_____
Have you ever been treated for substance abuse? Yes No When?_____
Any religious beliefs that would affect medical care? Yes No (describe)_____

Hobbies:_____

Travel history:

Country visited	Year	Any health problems during/afterwards?

Exercise: How many minutes/day on average?_____How many days/week?_____

What types of exercise?_____
How many hours of screen time per day (add up time on computer, TV, video games, phones and other electronic devices)_____
How physically fit do you think you are right now? Unfit Below average Average Above average Very fit

How much sleep do you get on an average night?_____

Sleep: How many hours on an average night?_____

Sleep problems: Yes No (describe)_____

How often do you drink caffeinated beverages?_____

Do you need the caffeine for energy? Yes No

When is your energy best?_____ Worst?_____

How would you rate your current stress level (1-10, 1 is very low, 10 is very high)?_____

Main sources of stress_____

How do you deal with your stress?_____

Family History: Please take some time and do some research, ask questions of family members to get as much information as possible before our appointment. Please include health problems or cause of death for those who are deceased, also.

Maternal = mom's side Paternal = dad's side

	Mother	Father	Children	Brother(s)	Sister(s)	Maternal grandmother	Maternal grandfather	Maternal aunt(s)	Maternal uncle (s)	Paternal grandmother	Paternal grandfather	Paternal Aunts	Paternal Uncle(s)	Other
ADD or ADHD														
Anxiety														
Arthritis, osteoarthritis														
Arthritis, rheumatoid														
Arthritis, other or unknown														
Asthma														
Autism														
Alzheimer's														
Bipolar disease														
Breast cancer														
Colon cancer														
Lung cancer														
Other cancer(s) (list under table)														
Celiac disease														
Depression														
Diabetes, type 1														
Diabetes, type 2														
Eczema														
Food allergies/sensitivities														
Genetic disorders (list under table)														
Gluten sensitivity														
Goiter														
Grave's disease														
Hirsutism (excessive body hair in women)														

	Mother	Father	Children	Brother(s)	Sister(s)	Maternal grandmother	Maternal grandfather	Maternal aunt(s)	Maternal uncle (s)	Paternal grandmother	Paternal grandfather	Paternal Aunts	Paternal Uncle(s)	Other
Heart disease in male under 55 yr or female under 65 yr														
High cholesterol or triglycerides														
High blood pressure														
Infertility														
Inflammatory bowel disease (Crohns, ulcerative colitis)														
Irritable bowel syndrome														
Learning disorders														
Lupus														
Migraines														
Obesity														
Osteoporosis														
Polycystic Ovarian Syndrome														
Psoriasis														
Precocious (early) puberty														
Prostate cancer														
Late puberty														
Rheumatoid arthritis														
Short adult height (woman less than 60” or man less than 66”)														
Tall adult height														
Schizophrenia														
Stroke														
Substance abuse														
Sudden Infant Death Syndrome														
Suicide														
Hashimoto’s														
Hypothyroidism														
Hyperthyroidism														
Other thyroid problems (list below)														
Other autoimmune problems (list below)														

Other family medical problems not mentioned already or needing further explanation:

Medications & Supplements

Please list your current medications and supplements, including hormones & over the counter products (attach list if necessary):

Name	Dose	Frequency	Start date (month/year)	Reason for use

Have any of these medications or supplements ever caused unusual side effects? No Yes (describe)

Are you very sensitive to medications or supplements? No Yes

Have you used any of the following in the past or present, either for regular use or prolonged use?

NSAIDs (Aleve, Advil, Motrin, aspirin)? No Yes (If so, for what?)

Tylenol? No Yes (if so, for what?)

Acid Blocking Drugs (Tagamet, Zantac, Prilosec, Nexium, etc) No Yes

How many times have you been on antibiotics in your life?_____ In the last 2 years?_____

For what?

Steroids (prednisone, nasal allergy inhalers)?No Yes (if so, why?)

Oral contraceptives? No Yes When?

Do you have any dental amalgams (silver fillings/caps?) No Yes

Do you live with a pet? No Yes (what kind/s?) How long? Any reactions? No Yes

Is there any evidence of mold in your home, school, place of work? No Yes Don't know

What kinds of jobs have you held in the past? (considering chemical or toxicant exposures)

Injuries: Please list any significant injuries, and the year. Please include broken bones, concussions, car accidents, etc.

Have you had any significant emotional trauma in your life?

General
□ Loss of appetite
□ Increased appetite
□ Fatigue
□ Fever
□ Frequent infections
□ Trouble falling asleep
□ Trouble staying asleep
□ Nightmares or night terrors
□ Sleepwalking
□ # hrs sleep/nite?_____
□ Salt cravings
□ Sugar cravings (candy, cookies)
□ Carbohydrate cravings (bread,pasta)
□ Unusual weight gain
□ Unusual weight loss
□ Picky eater
□ Anorexia
□ Binge eating
□ Bulimia
□ Can't gain weight
□ Can't lose weight
□ Frequent dieting
□ Caffeine dependency

Skin
□ acne
□ Athlete's foot
□ Birthmark(s)
□ Bumps on back of arms
□ Coarse or brittle hair
□ Dandruff
□ Dark circles under eyes
□ Dry skin
□ Eczema
□ Hair loss
□ Jock itch
□ Oily skin
□ Hives
□ Pale skin
□ Psoriasis
□ Rash
□ Strong body odor
□ Warts

Nails
□ Bitten
□ Brittle or fragile nails
□ Curved up
□ Fungus: finger nails
□ Fungus: toenails
□Pitted
□ Ragged cuticles
□ Ridges
□ Thickened
□ White spots/lines

Eyes/Ears/Mouth
□ Change in vision (other than glasses)
□ Color blindness
□ Double vision
□ Eye redness/conjunctivitis
□ Wears glasses or contacts
□ Hearing loss or problem
□ Frequent ear infections
□ Ears get red
□ Ringing in ears
□Vertigo/spinning sensation
□ Frequent nosebleeds
□ Frequent colds
□ Nasal congestion
□ Post-nasal drip
□ Seasonal allergies
□ Sinus infections
□ Bad breath
□ Bad teeth
□ Bleeding gums or periodontal disease
□ Lots of strep throat
□ Hoarseness
□ Frequent canker sores
□ Difficulty swallowing
□ Dry mouth
□ Decreased sense of smell
□ Braces or retainer
□ Lots of cavities
□ Dental problems
□ Root canal
□ Amalgam (silver) fillings

Neck
□ Neck mass or lump
□ Neck swelling
□ Swollen glands
□ Goiter/enlarged thyroid
□ Dark color around neck
□ Difficulty swallowing

Respiratory
□ Asthma or wheezing
□ Bad breath
□ Chronic cough
□ Difficulty breathing with exercise
□ Apnea/stopping breathing
□ Snoring
□ Frequent pneumonia/bronchitis

Heart/Vessels
□ High blood pressure
□ Low blood pressure
□ Fainting
□ Palpitations
□ Heart murmur
□ Varicose veins
□ Heart arrhythmia

Digestive
□ Abdominal pain
□ Black, tarry stool
□ Bloating
□ Bloating after meals
□ Bloody stool
□ Burping
□ Constipation
□ Cramps
□ Diarrhea
□ Alternating diarrhea & constipation
□ Excessive gas
□ Fissures
□ Full after small amounts of food
□ Heartburn/reflux
□ Hemorrhoids
□ Indigestion
□ Intolerance: Lactose
□ Intolerance: All dairy products
□ Intolerance: Wheat
□ Intolerance: Gluten (wheat/barley/rye)
□ Intolerance: corn
□ Intolerance: eggs
□ Intolerance: fatty foods
□ Intolerance: yeast
□ Intolerance/other:
□ Irritable bowel syndrome
□ Liver disease/jaundice
□ Abnormal liver tests
□ Nausea
□ Vomiting
□ Mucus in stools
□ Undigested food in stools
Stool frequency_____per day

Endocrine
□ Feel cold a lot
□ Feel hot a lot
□ Decreased sweating
□ Excessive sweating
□ Excessive thirst
□ Excessive urination
□ Hypoglycemia
□ Shaky or irritable when hungry
□ Cold hands or feet

Urinary
□ Blood in urine
□ Frequent urination
□ Dysuria/burning urination
□ Kidney stones
□ Leaking/incontinence
□ Urinating at night
□ Urgency (have to go NOW)
□ Recurrent urinary infections

Musculoskeletal
□ Arthritis
□ Back pain
□ Joint pain
□ Joint swelling
□ Muscle cramps
□ Muscle weakness
□ Muscle aches
□ Broken bones
□ Scoliosis
□ TMJ

Nerves/Mood
□ Anxiety
□ Clumsiness
□ Depression
Difficulty with
□ concentrating
□ balance
□ thinking
□ judgment
□ speech
□ memory
□ Fainting
□ Fearfulness/phobias
□Hallucinations
□ Headaches
□ Migraines
□ Hyperactive
□ Lightheaded
□ Numbness
□ Seizures
□ Tingling
□ Tremor

Hematology
□ Easy bruising
□ Prolonged bleeding
□ Excessive bleeding

Lymph Nodes
□ Enlarged nodes
□ Tender nodes

FOR WOMEN ONLY

Menstrual history
Age periods started
Did you start developing puberty early (before 8 yr old)? Yes No If so, what age?
Date of last menstrual period
How many days from start of one period to the next?
How many days does your period last?
Is the flow Heavy? Medium? Light? How many pads or tampons used on heavy days?
Date of last mammogram and findings:
Date of last pelvic exam/Pap smear and findings:
Do you have PMS or PMDD? Yes No If yes, what symptoms?
Birth Control Methods
Have you ever used birth control pills? Yes No
Have you ever used an IUD? Yes No If so, what type?
Describe any problems with pills or IUD:

Please circle any of the following symptoms you are having:

Spotting between periods	Nipple discharge	Vaginitis
Passing clots	Extra body/face hair	Vaginal discharge
Cramps before periods	Cramps during periods	Breast tenderness

Pregnancies

Have you ever been pregnant? Yes No	How old were you during pregnancies?
Describe any complications with pregnancies/deliveries:	
Did you breastfeed? Yes No	If so, how long?
Number of miscarriages:	
Any medical complications? Yes No	
Number of stillbirths:	Reason(s):
Number of premature births:	Reason(s):
Number of Cesarean sections:	Reason(s):
Number of abortions:	Reason(s):

Menopausal History

Age and year of menopause
Have you ever taken estrogen or hormone replacement (HRT)? Yes No
If so, age you started: # years of estrogen or hormone replacement:

Please circle any of the following symptoms you are having:

Hot flashes	Night sweats	Memory problems
Decreased sex drive	Vaginal dryness	Painful intercourse

FOR MEN ONLY

Do you have a history of undescended testicles? Yes No
Did you develop puberty late? Yes No
Did you develop puberty early? Yes No

Please circle any of the following symptoms you are having:

Low sex drive	Decreased muscle mass	Prostatic hypertrophy
Erectile dysfunction	Prostatitis	Weak urine stream
Man boobs/gynecomastia	Hot flashes	Nipple discharge

EATING PATTERNS Please circle your answers where appropriate

How many days per week do you eat breakfast?_____ at home fast food

What are some typical breakfast meals and beverages? (please be as specific as possible)

Is there a midmorning snack? Yes No If so, what foods/drinks?

For lunch: bring from home fast food other

What are some typical lunch meals and beverages?

What do you typically eat and drink for afternoon snacks?

What are some typical dinner meals and beverages?

Evening snacks/beverages:

How many meals per week do you eat at fast food restaurants?_____

How much of the following beverages do you drink in an average DAY?

Milk_____whole 1% 2% skim flavored Juice/juice drinks_____

Soda_____regular diet Sports drinks_____

Sugar free/flavored waters etc_____ Plain water_____

Sweet tea_____Unsweet tea_____ Coffee_____

Other:_____

Water source at home: City Well Filtered (how?) Distilled

How many servings of fruit in an average day?_____

How many servings of vegetables in an average day?_____

Cravings for any particular or unusual foods or drinks? No Yes If so, what?

Do you follow any particular eating plan? Vegetarian Vegan Paleo Raw Atkins Mediterranean

Macrobiotic Other:_____

Are you gluten free? Yes No Dairy free? Yes No Soy free? Yes No

Organic? Yes No Usually Sometimes