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. Jenny Hall, my assistant, and I, will do our best to assist you.

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, upload them to the Practice Better platform I use for email and scheduling, or bring them by in person.**

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, but intervals vary.

Video and phone visits are available, and you can choose those options in the Practice Better patient portal. I always prefer in-person visits, but if you live a distance away, I can see you in person at least once a year, and meet virtually in-between.

Payment will be due at the end of the appointment, by cash, check, HSA, or credit card. If paying by card, there will be a 3% fee added.

Contact us: I will invite you to join our secure Patient Portal on Practice Better. This portal will allow you to schedule appointments online and email Jenny and me. You may also call, should you have any questions during the course of your treatment.

Emails: I use the Practice better portal for password-protected, HIPAA compliant emails. Please allow 1- 2 days for responses. You are welcome to ask questions via email, but if your questions are complex, I'll ask you to schedule an appointment to discuss issues in detail.

I use my Face Book page https://www.facebook.com/pages/Patty-Powers-MD/457560211067399 and my website email newsletters to announce educational events, workshops and group programs. I encourage you to like my page and stay informed, and sign up for my newsletters on my website.

Website: www.drpattypowers.com

Lab results: For LabCorp tests, you can set up a patient account with LabCorp or Quest to view results. You will also be able to see your results thru the patient portal on Praxis, my electronic medical record (you can set up an account for that, too). I will either give you copies of your results when we meet, or email them to you through the Practice Better program.

Location: I am located in the Virginia Vein and Wellness practice. Jenny and I are usually in the office on Mondays and Thursdays.

Please note: I am not part of the Virginia Vein and Wellness practice, so please call my number to reach me, not theirs.

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

To health in all areas of your life,

Patty Powers, MD

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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

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.

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?

To tell the story of your health issues, I want you put together a timeline of your life and health. Get out a sheet of paper and map out in chronologic order everything that you can think of that might impact your health, starting from childhood through now. Include when symptoms started, a brief summary of what tests showed, what happened next, what treatments you tried, how they worked (or not). Many factors can contribute to health issues, including surgeries & anesthesia, hospitalizations, vaccinations, infections, toxin exposures, root canals, emotional and physical trauma, and head injuries. I'm including a link to Dr Izabella Wentz' timeline as an example.
https://thyroidpharmacist.com/wp-content/uploads/2015/11/sample_timeline.pdf

Where you live can also be important, such as living on a farm (pesticides) or having a flooded home or office or school (mold), or home renovation projects (lead, asbestos, mold, VOC's).

Please use more than one sheet of paper if you need to!
Doing this once will serve you well in the future, as you can keep a copy and add to it as needed. It will save you a lot of time when meeting new doctors.

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

Medications & Supplements

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

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

Your early years

Did your mother have any trouble with her pregnancy with you? Yes No Describe:
Were you born at [ ]full term? [ ] premature? If premature, how many weeks gestation? C/section Vaginal delivery Forceps
Were there any problems with delivery? Yes No Describe: Were there any problems in the first week after delivery? Yes No Describe: Did your mother breast-feed you? Yes No
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:

Please circle any problems you have had as an adult, or have now :

ADHD
Anemia
Anxiety
Panic attacks
Arthritis
Asthma
Bipolar
Blood disorder (what?)
Cancer (what type?)
COVID
Depression
Diabetes
Eczema
Endometriosis
Fibrocystic breasts Food sensitivities
Gall bladder disease
GERD/reflux
Headaches
Heart attack
Heart disease
Hepatitis
High cholesterol
HIV/AIDS
Hives
Hypertension
Hypoglycemia
Inflammatory bowel disease
IBS
Infertility
Jaundice
Kidney disease
Liver disease
Lung disease
Lyme/tick disease
Meningitis
Menstrual irregularities
Mold illness
Muscle disease
OCD
Osteopenia
Osteoporosis
Parasites
Periodontal disease
PCO
Prostatitis
Recurrent infections
Seizures
Thyroid problems
Urinary infections
Uterine fibroids
Vaginitis
Other:

Anything not already mentioned?

Dental history: root canal/s No Yes how many?_____ When?_____

Amalgam (silver) fillings No Yes How many?_____

Have you had amalgam fillings removed? No Yes when?_____

Any teeth removed? No Yes Dry socket? No Yes Dental implants? No Yes if so, what kind?_____

Genetics: Have you had any genetic testing? Yes No If so, what did it show?

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?

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, now Yes, in past (If so, for what?)

Tylenol? No Yes, now Yes, in past (if so, for what?)

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

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, now Yes, in past (if so, why?)

Hormone replacement therapy? No Yes, now Yes, in past which hormone/s?_____

For Women

Birth Control Methods: current method:
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:

Pregnancies

Have you ever been pregnant? Yes No	How many times have you been pregnant?
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):

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

Immunizations: Up to date Avoid do you get an annual **flu vaccine**? Yes No

COVID vaccines: No Yes **Pfizer Moderna J&J when:**_____

Shingles vaccines: No Yes When_____

HPV vaccines: No Yes When_____

Any problems from immunizations? No Yes Describe:

Lifestyle

Status: Pediatric Single Married Widowed Divorced # children_____

Occupation:_____ Employer_____Yrs Employed_____
Full time Part time

Who is living in household? _____
Are you currently a student? Yes No If so, what is your current level?
Do you smoke? Yes No amount/day_____ Did you smoke in the past? Yes No
How many years?_____ When did you quit?_____
Vape? Yes No
Any smokers in the home? Yes No

Have you ever used marijuana? Past user current user 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? No Yes When?_____
Any religious beliefs that would affect medical care? No Yes (describe)_____

Hobbies:_____

Exercise: How many hours/week 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

Does exercise: energize you? wear you out? Neither

Sleep: Sleep problems: No Yes (describe)_____

How many hours on an average night?_____ Sleep is: Refreshing? Unrefreshing?

When is your energy best?_____ Worst?_____

How often do you drink caffeinated beverages?_____

Do you need the caffeine for energy? Yes No

Stress: How would you rate your current stress level? Low Moderate High

Main sources of stress_____

How do you deal with your stress?_____

EATING PATTERNS

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

Other:_____

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

Organic? Yes No Usually Sometimes

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: home-made fast food sit-down restaurant 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?_____

What kinds of fats & oils do you cook with?

What kinds of fats &n oils do you use at the table?

What kind of salt do you use?

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/County Well

How Purified/ Filtered? Fridge filter Brita or similar Distilled Bottled Alkaline

Berkey Reverse Osmosis None

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?

Travel history:

Country visited	Year	Any health problems during/afterwards?

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

Does your home smell musty? No Yes Any water damage or flooding in your home or work or school? No Yes

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

Any implants? (breast, joint, cardiac stents?) No Yes_____

Do you use pesticides (bug killers) in or around the home? No Yes Termite service? No Yes

Do you use Glyphosate (RoundUp) around the yard/garden? No Yes Professional yard care? No Yes

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														
Prostate 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														
Late puberty														
Schizophrenia														
Stroke														
Substance abuse														
Sudden Infant Death Syndrome														
Suicide														
Hashimoto's														
Hypothyroidism														
Hyperthyroidism														
Other thyroid problems (list below)														
Other autoimmune problems (list below)														

Any other family history not mentioned above?

Please mark your current and/or recurrent symptoms here:

General
□ Fatigue
□ Fever
□ Loss of appetite
□ Increased appetite
□ Unusual weight gain
□ Unusual weight loss
□ Can't gain weight
□ Can't lose weight
□ Frequent dieting
□ Frequent infections
□ Salt cravings
□ Sugar cravings (candy, cookies)
□ Carbohydrate cravings (bread,pasta)

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

Nails
□ Brittle or fragile nails
□ Ridges
□ Thickened
□ White spots/lines
□ Nail fungus

Eyes/Ears/Mouth
□ Change in vision (other than glasses) □ Double vision
□ Eye redness/conjunctivitis
□ Wears glasses or contacts
□ Hearing loss or problem
□ Frequent ear infections
□ Ringing in ears
□ Vertigo/spinning sensation
□ Frequent nosebleeds
□ Frequent colds
□ Nasal congestion
□ Post-nasal drip
□ Seasonal allergies
□ Sinus infections
□ Bad breath
□ Bleeding gums
□ 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

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

Respiratory
□ Asthma or wheezing
□ Chronic cough
□ Difficulty breathing with Exercise
□ Snoring
□ Sleep apnea
□ CPAP
□ Frequent pneumonia/bronchitis

Heart/Vessels
□ High blood pressure
□ Low blood pressure
□ Fainting
□ Dizziness on standing up
□ Chest pain
□ Palpitations
□ Heart murmur
□ Varicose veins
□ Heart arrhythmia
□ Swelling of feet or legs
□ Raynaud's

Digestive
□ Abdominal pain
□ Black, tarry stool
□ Bloating
□ 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
Stool frequency_____per day

Endocrine
□ Feel hot a lot
□ feel cold a lot
□ Excessive sweating
□ Decreased 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 pain
□ Broken bones
□ Scoliosis
□ TMJ
□ Double or loose-jointed

Nerves/Mood
□ Anxiety
□ Brain fog
□ Clumsiness
□ Depression
Difficulty with
- □ concentrating
- □ balance
- □ thinking
- □ judgment
- □ speech
- □ memory
- □ word-finding

□ Fainting
□ Fearfulness/phobias
□ Hallucinations
□ Headaches
□ Migraines
□ Hyperactive
□ Numbness
□ Tingling
□ Ice pick pains
□ Seizures
□ Tremor

Hematology
□ Anemia
□ Easy bruising
□ Prolonged bleeding
□ Excessive bleeding

Lymph Nodes
□ Enlarged nodes
□ Tender nodes

For Women

Menstrual history: How old were you when you had your first period?
If you are still menstruating:
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?
For menopausal women: Last menstrual cycle:
Date of last mammogram and findings:
Date of last pelvic exam/Pap smear and findings:

Please circle any that apply to you currently or on an ongoing basis. If you have PMS or PMDD, describe in space to right:

Breast lumps/masses	PMDD
Breast pain/tenderness	Extra face/body hair
Nipple discharge	Cramps before periods
Fibrocystic breasts	Cramps during periods
Irregular periods	Hot flashes
Heavy periods	Night sweats
Scanty periods	Memory problesm
Vaginitis	Decreased sex drive
Vaginal discharge	Vaginal dryness
PMS	Painful intercourse

For Men

Do you have a history of undescended testicles? 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