BRADENTON EAST INTEGRATIVE MEDICINE – DIVISION OF NEUROMUSCULOSKELETAL MEDICINE AND NON-SURGICAL ORTHOPEDICS

FUNCTIONAL/INTEGRATIVE MEDICINE FOLLOW-UP VISIT FORM

PATIENT NAME _____ AGE _____ DOB _____

PLEASE BE ADVISED THAT DR. LEIBER REQUESTS THAT YOU MAINTAIN A RELATIONSHIP WITH A PRIMARY CARE PHYSICIAN FOR ROUTINE MEDICAL CARE AND ACUTE MEDICAL NEEDS.

1) **PRIMARY CARE PHYSICIAN:**
   a) **NAME:** _____ **LAST VIST:** _____
   b) **LAST FULL PHYSICAL:** _____

2) **DO YOU SEE A PAIN MANAGEMENT PHYSICIAN:** ☐ Yes ☐ No
   NAME: _____ **LAST VISIT:** _____

3) **REASON FOR THIS VISIT:**

_____

_____

_____

☐ **REVIEW LABORATORY TESTS:** ☐ Yes ☐ No

IF YES:
- ☐ ROUTINE LABS
- ☐ GASTROINTESTINAL PROFILE
- ☐ HORMONE PROFILE (MALE OR FEMALE)
- ☐ CARDIOVASCULAR PROFILE
- ☐ NUTRITIONAL PROFILE
- ☐ IMMUNE SYSTEM PROFILE
- ☐ INSULIN RESISTANCE OR DIABETES PROFILE
- ☐ BONE METABOLISM PROFILE
- ☐ TOXICANT ANALYSIS (e.g. HEAVY METALS)
- ☐ FOOD SENSITIVITIES
- ☐ GENETIC PROFILE
- ☐ BIOPSY / CULTURE
- ☐ OTHER _____

☐ **REVIEW IMAGING OR OTHER TESTING:** ☐ Yes ☐ No

IF YES:
- ☐ BONE DENSITY
- ☐ MRI
- ☐ CAT SCAN (CT)
- ☐ ULTRASOUND
- ☐ EMG/NERVE CONDUCTION STUDY
- ☐ SLEEP STUDY
- ☐ OTHER _____

☐ **REVIEW OF MEDICATIONS OR SUPPLEMENTS:** ☐ Yes ☐ No

IF YES, WHICH MEDICATION OR SUPPLEMENT IN PARTICULAR DO YOU WANT TO DISCUSS?

_____

IF YES: LIST CURRENT MEDICATIONS AND SUPPLEMENTS (OR PROVIDE SEPARATE LIST)

NAME	DOSE/AMOUNT	FREQUENCY

4) **DIET:** Do you currently follow a **Specific Diet or Nutritional program**? ☐ Yes ☐ No
   a) Are you seeing a **nutritional counselor or dietician**? ☐ Yes ☐ No
   b) Do you **Cook**? ☐ Yes ☐ No
   c) Do you **Grocery Shop**? ☐ Yes ☐ No
   d) Do you **Read Food Labels**? ☐ Yes ☐ No
   e) How many **Servings of Fruits/Vegetables** do you have per day (do not include fruit juice, potatoes, or processed foods)?

      _____

   f) How many times per week do you **Eat Out** (include: breakfast, lunch, dinner, and dessert/snacks)?

      _____

5) Do you **EXERCISE**? ☐ Yes ☐ No What type and How often?

_____

_____

6) What are your **HOBBIES/INTERESTS**? _____

7) Do you currently have or have you had any **ENVIRONMENTAL EXPOSURES** to chemicals/toxins/radiation?

   _____

   a) Are you **SENSITIVE TO ANY ENVIRONMENTAL CHEMICALS** (e.g. perfumes/colognes, auto exhaust, MSG, etc)? _____

REVIEW OF SYSTEMS/SYMPTOMS

(Check any symptoms or findings that you have experienced recently)

CONSTITUTIONAL ☐ weight change ☐ fatigue ☐ fever ☐ night sweats ☐ general weakness

EYES ☐ vision problems ☐ double vision ☐ yellowing of the eyes

ENT ☐ hearing problems ☐ dizziness ☐ sinus trouble ☐ sore throat ☐ ringing ears ☐ bleeding gums ☐ periodontal disease

CARDIOVASC ☐ shortness of breath ☐ chest pain ☐ leg swelling ☐ increased blood pressure

RESPIRATORY/SLEEP ☐ cough ☐ coughing up blood ☐ wheezing ☐ asthma ☐ other difficulty breathing ☐ snoring ☐ gasping for air during sleep ☐ fall asleep during the day ☐difficulty falling asleep ☐ difficulty staying asleep

GASTROINTESTINAL ☐ trouble swallowing ☐ heartburn ☐ nausea ☐ vomiting ☐ diarrhea ☐ blood or black tarry stools ☐ abdominal pain ☐ gas ☐ bloating

GENITOURINARY ☐ pain with urination, blood in urine ☐ urgency ☐ incontinence ☐ increased urination ☐ impotence/erectile dysfunction (for males) ☐ prostate problems (males)

MUSCULOSKELELTAL ☐ joint pain ☐ joint stiffness ☐ muscle cramps ☐ muscle twitching ☐ muscle weakness ☐ loss of motion ☐ tendonitis ☐ swelling of finger or other joints ☐ redness of joints

SKIN/HAIR/NAILS ☐ rash ☐ lumps/masses ☐ itchy ☐ dryness ☐ hair changes ☐ nail changes ☐ yellowing of the skin

NEUROLOGICAL ☐ fainting ☐ blackouts ☐ seizures ☐ paralysis ☐ weakness ☐ numbness ☐ memory loss ☐ numbness in a saddle distribution (inner legs and groin)

PSYCHOLOGICAL ☐ nervousness ☐ tension ☐ mood changes ☐ depression ☐ anxiety

ENDOCRINE ☐ decreased libido ☐ heat or cold intolerance ☐ excessive thirst ☐ increased hunger ☐ increased craving for sweets or carbs ☐ low blood pressure ☐ hot flashes

HEMATOLOGY/ONCOLOGY ☐ easy bruising ☐ bleeding (difficulty clotting) ☐ venous thrombosis (clots) ☐ current or history of cancer