pacific frontier
MEDICAL

Patient Demographics:

Name:_____Date:_____

Address:_____

City:_____State:_____ Zip Code:_____

DOB (mm-dd-yyyy):_____ Age: _____ Sex:_____

Phone: Primary:_____ Mobile:_____

Alternate #:_____ Fax (if applicable):_____

Email Address:_____

Emergency contact Name:_____ Relation:_____

Emergency Contact Phone #:_____

Patient Occupation:_____

If Disabled; Previous Occupation:_____

Referring Physician (if applicable) :_____

Referring Physician's Phone #:_____

Primary Care Physician Name: _____

Primary Care Physician Phone #: _____

Doctors who have treated you for Lyme in the past (if applicable)- please include Naturopath's ect.

_____

_____

Please answer the following questions: (If more space is needed please attach separate sheet)

Present well being: Poor Below average Average Fairly good Good

Overall how do you feel today? _____

Have you been diagnosed with Lyme disease? Yes No

If yes, by whom? _____

Most Prominent Symptoms: _____

_____

Are you on antibiotics? Yes No

If yes, please list all antibiotics, dosage and duration:_____

_____

_____

List previous antibiotics, dosage and duration:_____

_____

List other medications, dosage and duration presently taking:_____

_____

Do you take supplements? Yes No If yes, What do you take?_____

_____

List any medication allergies:_____

List any other allergies:_____

Are you pregnant: Yes No If yes, how many months?_____

Have you had problems with previous pregnancies? Yes No

If yes, please explain:_____

Are you taking contraceptives? Yes No

Do you smoke? Yes No If yes, how long?_____Quantity:_____

Do you exercise? Yes No If yes, type:_____

Diet/Eating habits:_____

Outdoor activities?_____

Do you have pets? Yes No If yes, what type?_____

How long?_____ Are they sick? Yes No

If yes, please explain:_____

States Previously Visited:_____

Areas Travelled to outside of United States:_____

_____

History of Tick Bite(s)

Do you remember getting a tick bite? Yes No

If yes, date of bite:_____ City/State where bitten:_____

Was the tick attached to your body when found? Yes No If yes, Where?_____

How long before it was removed? _____

Was the tick identified? Yes No If yes, what type of tick?_____

Symptoms after the tick bite:_____

_____

Generalized date of onset of symptoms?_____

Dermatological

Was there a rash at the bite site? Yes No

If yes, describe the rash:_____

How long after the bite did the rash occur?_____

Duration of rash?_____

Was there a "Bullseye" lesion? Yes No If yes, Duration?_____

Have you been diagnosed with the following?

Please circle all the pertains to you:

ALS
Alzheimer's Disease
Anemia
Asthma
Autism
Bakers Cysts (behind knee)
Bell's Palsy
Bursitis (where?_____)
Carpel Tunnel Syndrome
Depression
Diabetes
PANS/PANDAS
Encephalitis
Fibromyalgia
Iritis
Meningitis
Multiple Sclerosis
Polymyalgia Rheumatica
Prostatitis
Psoriasis/eczema
Stroke (Permanent / Temporary)
Tendonitis
TMJ

Special Children's Questions:

Decreased interest in playing? Yes No

Poor school performance? Yes No

When did he/she start whimpering or whining?_____

Clinical Signs and Symptoms:

Please circle all the pertains to you:

General

Fatigue
Fevers- high/low
Flu-like symptoms
Loss of voice/hoarseness
Loss of appetite
Hair Loss
Sore throats
Night sweats
Unexplained chills
Unexplained weight change
Other_____

Heart and Lung

Abnormal Echocardiogram
Chest pain/tightness
EKG abnormalities
Heart attack
Heart Palpitations
Skipped heart beats
Increase blood pressure
Mitral valve prolapse
Shortness of breath
Cough (dry/productive)
Other_____

Ear & Eye

Blind spots
Blurred vision
Conjunctivitis
Diminished peripheral vision
Double vision (horizonal/vertical)
Drooping eyelids
Flashing lights
Floaters
Lazy eye
Light sensitivity
Optic atrophy
Pressure behind the eyes
Retinal damage
Uveitis (inflammation of the eye)
Ringing in the ears
Hearing loss/deafness (one or both ears)
Other_____

Musculoskeletal

Muscle pain/aching
Muscle cramps/stiffness
Loss of muscle tone
Jaw pain/stiffness
Back pain/stiffness
Neck pain/stiffness
Joint pain/stiffness
Hand pain/swelling
Elbow pain/swelling
Shoulder pain/swelling
Hip(s) pain/swelling
Knee pain/swelling
Feet/ankle pain/swelling
Leg aches
Other_____

Neurological

Abnormal EEG
Anxiety attack
Burning sensation (internal/external)
Change in smell/taste
Confusion
Decreased concentration
Dementia
Depression
Difficulty chewing/swallowing
Dizziness/fainting
Fatigue
Hallucinations
Headache (mild/severe)
Involuntary jerking
Irritability
Memory problems
Meningitis
Mood swings
Motion sickness
Muscle twitching
Nightmares
Numbness (Where?_____)
Obsessive/compulsive behavior
Panic attacks
Paranoia
Partial paralysis (Where?_____)
Personality change
Poor Balance or difficulty walking
Seizures
Sleep disturbance
Suicidal
Tearfulness
Tingling (Where?_____)
Tremors or shaking
Weakness of limbs
Unusual clumsiness
Other_____

Gastrointestinal & Urinary

Abdominal pain
Constipation
Diarrhea
Diverticulosis
Irritable bladder
Liver enlargement
Nausea
Spleen enlargement
Tenderness in abdomen
Urinary frequency/retention
Vomiting
Other_____

Reproductive

Breast (infections/ discharge)
Loss of Libido
Menstrual irregularities
Pelvic pain
PMS
Other_____

Abnormal Lab Results (Circle all that apply and document date and lab)

	Date	Lab
Positive Lyme ELISA/IFA	_____	_____
Positive Lyme Western Blot/Immunoblot	_____	_____
IgG	_____	_____
IgM	_____	_____
Positive Lyme PCR	_____	_____
Positive Lyme Culture	_____	_____
Positive LDA	_____	_____
Other Positive Lyme test(s)	_____	_____
_____	_____	_____
_____	_____	_____
Positive Babesia test	_____	_____
Positive Ehrlichea test	_____	_____
Positive Bartonella test	_____	_____
Positive Mycoplasma	_____	_____

List all other tests to substantiate diagnosis:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other information that would be pertinent to your symptoms or diagnosis: