Ralph T. Golan, M.D.
Family and Preventive Medicine

Ravenna Medical Arts
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Name________________________________

Address______________________________

City_________________ State_____ Zip ________

Birthdate____________________ Age _________

Home phone ____________________________

Work phone ____________________________

Cellphone ______________________________

E-Mail_________________________________

Today's Date________________________

Occupation _________________________

Employer____________________________

Medical Insurance____________________

Group # ____________________________

Medicare #___________________________

How did you hear of Dr. Golan__________

____

All information that you volunteer will remain confidential unless you authorize its release

What do you hope to accomplish from your visits here

____

____

____

What are the main problems, areas, or challenges for which you wish assistance, and for how long, approximately, have they existed? Briefly list:

1.____
2.____
3.____
4.____

What are the minor problems, areas, and challenges for which you wish assistance, and for how long approximately have they existed? Briefly list:

1.____
2.____
3.____
4.____

How would you describe your general sense of well-being?

____

____

What is your stamina or general energy level like?

____

Does your energy or well-being vary with the time of day, with the weather or seasons, eating, or with any other factor of which you are aware? Describe:

____
____
____

YOUR DIET

Please write down two samples of each meal (what you eat every day or nearly every day).Include what you drink with meals, desserts, and snacks:

Breakfast 1.______________________________
2.______________________________
Morning snack ______________________________
Lunch 1.______________________________
2.______________________________
Afternoon snack ______________________________
Dinner 1.______________________________
2.______________________________
Evening snack 1.______________________________

Food Intake

For each question fill in the circle that reflects your usage most accurately

- Dairy Products
(milk, cheese, cottage cheese, yogurt, ice cream, goat milk, soy milk, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Eggs

more than once a day O once a day O 2-3 times a week O less often O

-Beans
(Pinto, black, red, garbanzo, navy, lentil, split pea, soy, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Grains
(Wheat, rye, corn, barley, triticale, buckwheat, millet, rice, oats, wild rice, amaranth, quinoas)

more than once a day O once a day O 2-3 times a week O less often O

-Uses of Grains
(Bread, rolls, muffins, scones, crackers, tortillas, pasta/noodles, cereals, bagels, pretzels, pastries, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Whole Grains (unrefined, unprocessed)
(whole wheat bread, whole wheat pasta, whole wheat rolls, brown rice, whole grain crackers, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Refined or processed grains
(white or French bread, white rolls, white rice, white flour, pasta, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-How often do you eat raw vegetables?

more than once a day O once a day O 2-3 times a week O less often O

-Starchy Vegetables (Potatoes, yams, winter squash, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Fresh green leafy vegetables
(Lettuce, spinach, kale, collard, chard, parsley, mustard greens, beat greens, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Other fresh vegetables
(Carrots, celery, broccoli, cauliflower, cabbage, cucumber, tomato, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Sprouts
(Alfalfa, clover, mung, sunflower, buckwheat.)

more than once a day O once a day O 2-3 times a week O less often O

-Vegetable juices (Carrot, tomato, greens)

more than once a day O once a day O 2-3 times a week O less often O

-Fresh fruits
(Apple, orange, banana, grapes, melons, pears, plums, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Dried fruits
(Raisins, dates, figs, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Fruit juices
(Orange, grapefruit, apple, berry)

more than once a day O once a day O 2-3 times a week O less often O

-Seeds and Nuts
(Sunflower, sesame, almond, filbert, cashew, walnut, peanut, pecan, etc)

more than once a day O once a day O 2-3 times a week O less often O

-Meat of any kind
more than once a day O once a day O 2-3 times a week O less often O

-Fermented foods
(Miso, tamari, sauerkraut, pickled vegetables, buttermilk, yogurt, kefir)

more than once a day O once a day O 2-3 times a week O less often O

-Meals eaten out at restaurants

more than once a day O once a day O 2-3 times a week O less often O

-Meals eaten at "fast food" establishments

more than once a day O once a day O 2-3 times a week O less often O

-Pre-prepared, Frozen or TV-type dinners

more than once a day O once a day O 2-3 times a week O less often O

-Fried or sautéed foods

more than once a day O once a day O 2-3 times a week O less often O

-Soft drinks (Coke, sprite, 7up, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-Sweets
(Cookies, cake, pie, ice cream, candy, pastries, soft drinks, sugar cereals, etc.)
more than once a day O once a day O 2-3 times a week O less often O

How many teaspoons of sugar daily do you add to foods/beverages? _______________

Coffee: Caffeinated/decaf; how many cups a day? _____________________________

Alcoholic beverages

What kind and how many per day or week? _____________________________

Water: Tap, filtered, spring, distilled, well/artesian; how many glasses a day _________

Other fluids not listed above____

How many glasses a day?____

Do you salt your food? (heavily, moderately, or not at all) _______________________

Do you eat highly salted foods like chips, etc.? _______________________________

How many artificially sweetened beverages do you consume? (daily, weekly) ________

How much artificial sweetener do you add to your food/beverages daily? ____________

Are you generally relaxed when you eat? ____________________________________

What is your appetite like at breakfast time? _________________________________

At lunch time? __________________________

At dinner time? _________________________

When does your body/digestive system seem most ready for your main meal of the day?

____

What foods or type of meals seem to make you feel or function best?

____

What foods or beverages do you crave? ______________________________________

What kind of cooking or salad oil do you use? _________________________________

Do you use margarine or butter? __________________ How much? _____________

LIFESTYLE

How much sleep do you normally get? ______ Do you awaken rested and refreshed ___

How much time every day do you spend indoors? ______ Outdoors? __________

How much physical exercise do you get, what kind, and do you feel it is sufficient?

____

Do you smoke? ____ How much? ______ For how long have you smoked _________

Do you have any interest in quitting? ______

Do you ever fast? _____ For how long, how often, and what kind? _______________

Do you meditate or do a skilled relaxation exercise? ________ how often? __________

GASTROINTESTINAL

Does food generally "sit" well in your stomach and digest without any difficulty? _____

How often do you have a bowel movement? ________________________________

Do your bowel movements feel complete? ________________________________

Are your bowel movements generally formed or loose? ________________________

Do you need to strain to have a bowel movement? ___________________________

Do you have hemorrhoids or any other rectal or bowel problems? ________________

ENVIRONMENTAL

What is the age of your current domicile? ______________________________

Do you have a gas or electric kitchen range? _____________________________

What kind of heat do you have? (gas, electric, oil, wood?) ___________________

Any recent remodeling, painting, staining, refinishing, particle board cabinets, or flooring, new carpets, glues, in the home or office? ___________________________

Any hobbies, activities, work, or locations that expose you to fumes, exhausts, combustion products, cigarette smoke, bad air, marker pens, solvents, paints, bug spray, etc. ____

Do you seem to react adversely to any of these exposures? ____________________

Any placement of dental metals (fillings, crowns, implants, bridges, etc.) or root canals within 3-6 months before the onset of your symptoms? ______________________

MORE MEDICAL HISTORY

Please list any present illnesses/conditions not listed above:

____

Has your weight ever been a difficult issue for you? ______ Weight change in the last six months: ______/ in the last year: ______ Current weight _______

List any drugs or medications you are taking (or have recently taken), include diet pills, birth control, aspirin, sleeping pills, anti-inflammatory pills, etc

____
____
____
____

List any vitamins or food supplements you are taking (amount in milligrams if you know)

____
____
____

List any allergies or adverse reactions to inhalants, foods, medicines, perfumes, etc.

____

Please list all surgeries, hospitalizations, and approximate dates if you can remember:

____
____
____

Please list any past illnesses/conditions not listed above and approximate dates (including; thyroid problems, parasites, worms, travelers diarrhea, mono, hepatitis, chronic fatigue syndrome, ulcers, gastritis, chronic or difficult yeast problems, or any other significant condition.)

____
____
____

Please list any significant injuries with approximate dates (especially head, neck and back trauma): ____
____

When was your last general medical exam? ____________________________________
When was your last blood test? _______ Stool test? _________ Urine test? _______

Are there any significant health problems in your family?

Mother's side	Father's side	Siblings
Mother__________________	Father _________________	_______________________
Aunts __________________	Aunts _________________	_______________________
Uncles _________________	Uncles _________________	_______________________
Grandmother ____________	Grandmother ___________	_______________________
Grandfather _____________	Grandfather ____________	_______________________

Current health status of those you live with (other than those listed above):

Children ____

Others ____

____

FEMALES

How regular are your menstrual periods? ______________________________________
Are they painful? _____ If so, please describe and include medications if applicable:

____
Any premenstrual or ovulatory symptoms? ____ How severe? ____________________
Date of your last period? __________________________
How long do your periods last? _____________________
Is there any spotting or bleeding between periods? ______
Total number of years you have ever been on birth control pills: ______
When were you last taking them? ____________
When was your last pelvic/pap test? ____________ Results? _____________________

Have you ever had an abnormal pap smear previous to that last one? __________

Have you ever had a mammogram? ______ Date: ______ Results: ________________
How many full term pregnancies have you had? ___________

SOCIAL/PERSONAL

How do you relax and how often? ____

____

____

How do you feel in your home or living situations? ______________________________

____

____

How do you feel in your work situations? _______________________________________

____

____

What do you love to do and how often do you do these things? _____________________

____

____

Do you have any goals or ambitions you would like to share with me? ______________

____

____

What emotions/feelings/thoughts do you commonly or repeatedly have? _____________

____

____

Is there any other information about yourself that you would like to add which would help this evaluation?

____

____

____

____

SYMPTOM SURVEY

Instructions: Grade the symptoms which apply to you with a (1) for mild or occasional; (2) for moderate or more than occasional; or (3) for severe or frequent. Some symptoms are repeated in several groupings. Although it will be repetitive, grade your in every grouping they appear. Leave blank if a symptom does not apply to you.

GROUP 1

If delayed or missed meals
__shaky or faint feeling
__fatigued or sleepy
__headaches
__depression
__anxious/nervous
__irritable or moody
__foggy/fuzzy brain
__can't work under pressure
__heart palpitations
Unrelated to meals
__insomnia
__caffeine or sugar cravings
__alcoholic or recovered alcoholic.

GROUP2

__fatigue
__frequent infections
__depression
__headache
__foggy headed
__poor memory
__hyperactivity/ learning disorder.
__diarrhea or constipation?
__gas/bloating
__arthritis/joint pain
__muscle pains
__frequent urination
__heart palpitations
__sore throat
__sinus trouble
__dark circles under eyes
__seizures
__ringing in the ears
__seizures
__less interest in sex
__hair loss
__infertility
__multiple miscarriages
__slow pulse
__water retention or edema
__carpel tunnel syndrome
__decreased sweating
__headaches often upon arising, later wear off.
__family member with low thyroid condition or who takes thyroid medication.
__dizziness
__high blood cholesterol

GROUP 3

__persistent sinus problems
__persistent throat irritations
__gas or bloating
__diarrhea or constipation
__vaginal yeast infections
__bladder infections
__premenstrual syndrome
__menstrual cramps
__fatigue
__recurrent colds, flus, etc.
__arthritis or joint pains
__muscle pains
__headaches
__depression
__chemical intolerance: can't handle fumes, exhausts, perfumes, smoke, etc.
__multiple food allergies
__lots of antibiotic
__more tan 2 years of birth control, past or now.
__cortisone or prednisone use
__chemotherapy
__rash or itching, anywhere
__fungal infections of the skin or nails.
__asthma
_coated tongue or thrush
__intolerance to alcoholic beverages.
__recurrent prostatitis

GROUP 4

__fatigue, physical
__fatigue, mental
__reduced initiative
__poor memory
__depression
__weight gain
__difficulty losing weight
__sensitive to cold
__cold hands and feet
__constipation
__dry or course skin
__menstrual cramps
__too heavy or too light menstrual periods
__premenstrual syndrome
__recurrent or prolonged respiratory infections
__impotence

GROUP 5

__depression
__irritability/anxiety
__hyperactivity
__behavioral abnormalities
__learning disability
__bad memory/concentration
__high blood pressure
__fatigue
__poor intellectual or academic performance
__abdominal pain
__anemia
__neuropathy/neuritis/ numbness/burning
__tremor/twitches/seizures
__heart palpitations
__recurrent infections
__miscarriages?stillbirths
__weakness
__headache
__rash
__recurrent infections

GROUR 7
__fatigue
__depression
__bad memory/concentration
__nervous/irritable
__awaken tired, unrefreshed
__feel exhausted at night, but too wired to sleep
__any sleep disturbance
__slow recovery from any stress: a late night, physical workout, argument, etc.
__low or no reserve
__easily overwhelmed
__easy injuries, slow healing
__allergies: inhalants, foods, chemicals
__recurrent infections
__headaches
__low blood pressure
__lightheaded on standing up
__diminished perspiration
__low body temperature
__hypoglycemia
__history of extreme or prolonged stress
__history of trauma,prolonged pain or inflammation
__history of chronic infection
__premenstrual syndrome
__hair loss
__osteoporosis

GROUP 10
__diarrhea
__constipation
__nausea
__poor appetite
__vomiting
__excessive gas
__bloating
__abnormally smelly stools
__bloody stools
__abdominal cramps or pain
__weight loss or difficulty gaining weight
__food allergies/intolerance
__asthma
__hives
__autoimmune disease
__irritable bowel
__difficulty overcoming yeast growth
__difficulty overcoming food allergies and intolerance

GROUP 8
__fatigue
__weakness
__depression
__apathy/lethargy
__hyperactivity
__headache
__insomnia
__poor memory
__confusion
__difficulty making decisions
__dizziness
__tinnitus/ear ringing
__diarrhea/constipation
__bloating
__achy muscles or joints
__acne
__itching
__hives or other rashes
__frequent urination
__water retention
__allergies
__frequent infections

GROUP 11
__diarrhea
__greasy or floating stools
__unsettled stomachs
__irritable bowel
__undigested food in stool
__weight loss or hard to gain
__hypoglycemia
__acne
__food intolerance

GROUP 10 CONTINUED….
__history of foreign travel
__traveler's diahhrea
__drinking untreated water camping, swimming, traveling
__history of parasites; treated or untreated
__unexplained fever rheumatoid or other "immunological" arthritis
__low white blood cell count
__elevated eosinophil count
__household member or sex partner with parasite or bowel symptoms

FOR MEN
__difficult urination
__excess dribbling

GROUP9
__heartburn or acid indigestion
__food just sits there in stomach
__get full to easily
__food feels heavy in stomach
__bloated after meals
__excessive gas
__constipations or IBS
__coated tongue
__bad breath
__stool abnormality, smelly
__weak, thin, cracked or peeling finger nails
__muscle cramps or spasms
__food allergies
__intestinal yeast
__osteoporosis
__hypoglycemia

FOR WOMEN *menstrual or premenstrual*
__depression
__felling fragile
__weight gain
__water retention
__headaches
__cravings: sugar, salt chocolate, etc.
__cystic breasts
__constipation or diarrhea
__uterine cramps
__irritable, moody
__bloating __breast pain
__acne __insomnia
__fatigue __back pain

MENOPAUSAL
__hot flashes __mood swings
__dry or irritated vagina
__sleep disturbance
__poor memory __low libido
__difficulty concentrating
__osteoporosis
__headaches
__urinary frequency

FOR MEN CONTINUED….
__frequent nighttime urination
__less desire for sex
__rectal, pubic or scrotal pain
__erection problems

OFFICE POLICY ON FEES, PAYMENT AND INSURANCE

Dr. Golan's initial comprehensive evaluation usually requires from one to two hours and his hourly rate is $450.00. Follow up visits (usually 30 minutes) are $225.00. For longer initial or follow up visits, there will be an additional charge prorated at Dr. Golan's hourly rate. (Please see our cancellation policy below.)

Any laboratory fees, vitamin injections, and nutritional supplements will be in addition to the visit fees.

We ask that your payment be made at the time of each visit (cash, check, Visa, Mastercard). We will provide you with a statement of services and payments which you may submit to your insurance carrier.

The fees for phone consultations will be based on time, prorated at Dr. Golan's hourly rate and handled at the time by credit card. The fee for any reports or paperwork done on your behalf by Dr. Golan will be based similarly.

Dr. Golan is not a participant with any managed care or HMO organizations and is not a participating provider with any insurance companies. Those companies which restrict coverage only to participating physicians will not likely reimburse you for any of Dr. Golan's services. Some insurance carriers, however, will cover services from non-participating physicians, but at a lower percentage rate. Check with your insurance carrier for coverage details. Insurance carriers without a restrictive physician list will reimburse Dr. Golan's services at their customary out of network rate.

REGARDING MEDICARE

Any services, laboratory costs or nutritional therapies for individuals whose primary insurance is Medicare will not be able to seek reimbursement whatsoever from Medicare. This office does not bill Medicare, nor can patients bill Medicare themselves. Medicare patients and Dr. Golan are, by law, required to sign a "Private Contract" which we will provide. If you have private primary insurance and Medicare is secondary, you may be able to seek reimbursement depending on your particular primary coverage (see above paragraph). Whether Medicare is primary or secondary, we ask that payment for all services be made at the time of each visit.

Our labs may be able to bill your insurance company directly for lab tests depending on the test in question. However, a $20.00 blood draw fee would be incurred if applicable. We recommend that some tests be prepaid along with submitted samples and that you submit the charges to your insurance.

CANCELLATION POLICY

If you need to cancel a new patient appointment, please give us at least 48 hours or more notice so that we may be able to offer your time to someone else. If you have a new patient appointment on a Monday that you need to change or cancel, and as we are not in the office on Fridays, we would ask that you call before 5:00 pm on the Thursday before your Monday appointment. For follow up appointments, please give us at least 24 hours notice of cancellation. If you do not give us this adequate notice of cancellation, we reserve the right to bill you for Dr. Golan's lost time.