LesleyJames MD
A healthy bridge between science and nature.

2851 Clover Street | Pittsford, NY 14534 | (585) 641-7102
FAX To: 851-8657

Name	Date of Birth	Appointment Date/Time
Address	City	State, Zip
Email	Home Phone ( )	Mobile Phone ( )

What are your goals for this visit?

_____

_____

_____

Concern (please rank by priority) Example: Headaches	Onset June 1998	Frequency 4 times/week	Severity mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Medical History

Please indicate if you have /or ever had

	Past	Present
Heart Disease	◯	◯
Hypertension	◯	◯
Cancer	◯	◯
Diabetes	◯	◯
Lung Disease (asthma etc)	◯	◯
Hepatitis	◯	◯
Digestive Disorder	◯	◯

List family members who have had these illnesses (siblings, parent, children,grandparent)

_____

_____

_____

_____

_____

_____

_____

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Seizures	○	○	_____
Thyroid Disease	○	○	_____
Other _____	○	○	_____
Other_____	○	○	_____
Other_____	○	○	_____

Comments _____

_____

_____

Allergies Medication	Reaction/Intolerances
_____	_____
_____	_____
_____	_____
_____	_____

Food	Reaction/Intolerances
_____	_____
_____	_____
_____	_____
_____	_____

Environment	Reaction/Intolerances
_____	_____
_____	_____
_____	_____
_____	_____

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Operations		Injuries	
What	When	What	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Tobacco

❍ Never Used ❍ Smoked from age _____ to _____ packs per day._____

Alcohol

❍ Never Used ❍ Estimated drinks per day_____

Recreational Drugs

❍ Never Used ❍ Frequency_____

Comments

_____

_____

What medications are you taking now? (include prescription and over-the-counter drugs.)

Medication	Reason	When Started	Dose per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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What vitamins//minerals/supplements are you taking now?

Brand or Other Name	Reason	When started	Dosage per day

How many times have you taken antibiotics in the last 10 years? _____

How many times have you taken oral steroid medication in the last 10 years? _____

Occupation

_____

What hobbies/interests do you have?

_____

_____

_____

_____

Who do you live with? (include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship

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What Physical Activity do you participate in?

_____

_____

_____

Would you like to discuss an exercise regimen?

_____

What are the major stressors in your life?

_____

_____

_____

What do you do to relax?

_____

_____

_____

Religious affiliation , past and present

_____

_____

_____

What prior experiences have you had with alternative medicine?

_____

_____

_____

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Nutrition Evaluation

Please list all foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages and condiments.

Food Item	How prepared (baked,fried etc)	Amount (cup, tbs, ounces, etc)

Is this a typical day for you? If not, why? Please describe:

_____

_____

_____

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How many servings of fruit do you eat/drink per day?
(one serving = 1 small fruit, 1/2 cup juice, 1/2 cup canned or chopped fruit, 1/2 dried fruit)

_____

How many servings of vegetables do you consume each day?
(one serving = 1/2 cup raw or cooked vegetables, 1cup fresh, green leafy vegetables, 1/4 cup dried vegetables, or 1 small piece)

Are you currently on a special diet? If so, please describe:

_____

_____

_____

_____

_____

_____

_____

_____

What type of oil or spreads do you add to your food?

_____

_____

What do you drink on a typical day?

_____

_____

How would you describe your relationship with food?

_____

_____

_____

_____

_____

Need more space?

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