WESTSIDE HEAD & NECK

Michelle Putnam, MD • Amanda Salvado, MD • Dorothy Wang, MD

3831 Hughes Avenue, Suite 504 | Culver City, California 90232 | www.westsidehn.com | 310.204.411 T | 310.204.4474 F

IMPORTANT FINANCAL INFORMATION

- Since different insurance companies have different coverage for allergy testing, patients are responsible for asking their insurance companies about coverage. PATIENTS ARE RESPONSIBLE FOR ANY AND ALL BALANCES NOT COVERED BY THEIR INSURANCE.

- When you call your insurance to inquire about allergy coverage, the following CPT code will help you find out what is covered.

  83516 (50 - 370 units); Immunoassay for analyte other than antibody or infectious agent antigen, qualitative or semiquantitative; multi-step method

IMPORTANT MEDICATION INFORMATION
BEFORE BEING TESTED FOR REACTIVE ANTIGENS, FOLLOW THESE GUIDELINES :

Food: Preferably do not eat 3 hours before blood draw, but DO drink plenty of water.

Daily Medications: Taken on a regular basis are acceptable
Examples: Medications for hypertension, asthma, heart disease,
5-10 mgs of Prednisone for chronic arthritis, IBS, etc.

Weekly Medications:
Examples: Methotrexate, etc.
Have blood draw the day before or the morning of next therapy

Short-Course Dose Medications:
Examples: Medrol dose pack
Have patient complete medication and wait 5 days before blood draw

High dosages of Vitamin C: (reduce to 2500 mg per day for 3 days)

Antihistamines: Stop 3-5 days before blood draw
(this can include over-the-counter medications like Tylenol PM which has an antihistamine in the formula)

Antibiotics: (bacterial or viral infection) Wait for acute symptoms to abate

Dental Antibiotic Prophylaxis: Can draw blood anytime

Anticoagulants: (call for details- 800-872-5228)
Do not take Aspirin within 3 hours before blood draw.

Note: Medications and Supplements
If early AM draw, take medications or supplements directly after blood draw
If medications or supplements have been taken- wait 3 hours before blood
Draw

Signature: _____ Date: _____

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Nutrition Intake Form

(please print)

First & Last Name _____ Today's Date _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____ Ht _____ Wt _____ Sex _____ Age _____ Date of Birth _____

Your Occupation/Employer _____ Emergency Contact (Name & Phone Number) _____

Primary Care Physician (Name, Practice, Location) _____

OB/GYN or Urologist (Name, Practice, Location) _____

Reproductive Endocrinologist (Name, Practice, Location) _____

How did you hear about us? (doctor, nurse, friend, website, flyer) _____

In case of a Press Event, would you be willing to share your story? ☐Yes ☐ No

If YES, please check which of the following we could contact you about:

☐ Print/Interview ☐ TV ☐ Radio ☐ Testimonial

Health History

What are the health problems for which you are seeking treatment? _____

How long have you had this condition? _____

What other forms of treatment have you sought? _____

Please list any surgeries or major health incidents (year and type) _____

Family Medical History _____

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What is your primary reason(s) for seeking nutrition counseling? Please describe current condition _____

_____

_____

Please list all medications (and dosages if possible) that you are currently taking or have taken in the past 2 months (vitamins, supplements, over-the-counter medications, herbs)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Family History (M= Mother, F= Father, G= Grandparents, B= Brother, S= Sister, C= Children, Sp= Spouse)

_____ Allergies _____ Arthritis _____ Cancer _____ Diabetes _____ Reproductive Disorders

_____ Thyroid Disease _____ Alcoholism _____ Heart Disease _____ Stroke _____ Autoimmune Disease

Please indicate if you currently have or have had in the past any of the following symptoms or diagnoses:

- ☐ Acne
- ☐ Antibiotic use (extended)
- ☐ Constipation
- ☐ Depression/Anxiety
- ☐ Diarrhea
- ☐ Dry hair
- ☐ Dry skin
- ☐ Endometriosis
- ☐ Facial hair growth
- ☐ Fatigue, sluggishness
- ☐ Feel cold often
- ☐ Feel hot often
- ☐ Fibroids
- ☐ Gas/bloating
- ☐ Hair loss/thinning
- ☐ Headaches
- ☐ Heartburn
- ☐ Hot Flashes
- ☐ Hypothyroid
- ☐ Irritable Bowel Syndrome
- ☐ Irritable/depressed during menses
- ☐ Leg/muscle cramps
- ☐ Less than 1 bowel movement per day
- ☐ Menstrual clotting
- ☐ Period cramps
- ☐ Polycystic Ovarian Syndrome
- ☐ STD
- ☐ Yeast Infections

☐ Other, list _____

Reproductive History

Regular menses cycle? ☐Yes ☐ No Date of last period _____ Clots? ☐Yes ☐ No

Pain or Cramping? ☐Yes ☐ No Flow is ☐ Heavy ☐ Medium ☐ Light Abnormal Discharge? ☐Yes ☐ No

Number of pregnancies _____ Number of births _____

Have you ever been on the birth control pill or any other form of hormonal contraception? _____

If yes, what type? _____ For how long? _____

How long have you been trying to conceive? _____

Have you sought ART previously? ☐Yes ☐ No If yes, what have you done? _____

If you have gone through in-vitro, how many eggs were retrieved and how many fertilized? _____

Has you partner been tested for any fertility-related problems? ☐Yes ☐ No

If yes, what were the results? _____

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Nutrition Information

On a scale of 1-10 (10 being extremely healthful), how do you rate your diet? _____

Please describe any current dietary restrictions that you may have _____

_____

Do you have food allergies? ☐Yes ☐ No If yes, please describe _____

_____

Have you made any recent changes to your diet? ☐Yes ☐ No If yes, please describe _____

_____

Please specify how many of the follow you eat *per week*:

_____ beans/legumes	_____ fresh vegetables	_____ red meat
_____ butter	_____ margarine	_____ refined carbs (crackers, chips, pasta)
_____ cheese	_____ milk	_____ sugar substitute
_____ chicken/turkey	_____ nut butters	_____ sweets (dessert, candy, cookies)
_____ eggs	_____ nuts & seeds	_____ tofu/soy
_____ fish	_____ olive oil	_____ whole grains
_____ fresh fruit	_____ pork/ham/bacon	_____ yogurt

Please indicate any foods that are not listed that you consume regularly _____

_____

Please specify how many of the follow you drink *per week*:

_____ alcohol	_____ diet soft drinks	_____ regular soft drinks
_____ caffeinated coffee	_____ fruit juice	_____ regular tea (black)
_____ decaf coffee	_____ green tea	_____ sports drinks
_____ diet drinks/aids	_____ herbal tea	_____ water

Please indicate any beverages that are not listed that you consume regularly _____

_____

What is your drinking water source? ☐ Tap ☐ Bottled ☐ Filtered ☐ Reverse Osmosis ☐ Distilled ☐ Well

How often do you choose organic fruits and vegetables and grass-fed/cage-free animal products? _____

What foods do you crave? _____

What foods do you avoid? _____

Why? _____

Do you snack during the day? ☐Yes ☐ No If yeas, please describe _____

_____

How many times per week do you eat breakfast? _____ Please describe your usual breakfast _____

_____

Please specify how many times you eat the following meals away from home *per week*:

_____ Breakfast _____ Lunch _____ Dinner

Do you generally cook your own meals? _____ How often? _____ Do you like to cook? ☐Yes ☐ No

Where do you do most of your grocery shopping? _____

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How would you describe most meals: ☐ Relaxed ☐ Rushed ☐ Standing up in front of the TV
☐ Seated at the table ☐ In the car ☐ Alone ☐ With family or friends

Do you feel you eat a wide variety of foods? ☐Yes ☐ No ☐ Unsure

How often do you consume sugar? ☐ Daily ☐ 3-4 times per week ☐ Occasionally ☐ Seldom/Never

Please specify which of the following are included in your diet: ☐ Fast Food ☐ Prepared Meals at Home ☐ Fresh
☐ Canned ☐ Frozen ☐ Boxed or Bagged ☐ Organic ☐ Conventional ☐ Free-Range/Grass-Fed

Do you have good energy levels? ☐Yes ☐ No ☐ Inconsistent Does napping help or make it worse? ☐Yes ☐ No

Can you attribute low energy to anything in particular? ☐ Yes ☐ No

If yes, please specify _____

Do you consider yourself ☐ Underweight ☐ Overweight ☐ Just Right

Please circle:

I have / have not previously used diet or exercise to lose or gain weight.

I have / have not previously used medications or supplements to lose or gain weight.

Do you diet frequently? ☐Yes ☐ No Are you currently on a diet? ☐Yes ☐ No

Do you, or have you ever used tobacco? ☐Yes ☐ No _____ # per day _____ # of years if quit, when? _____

Do you drink alcohol? ☐Yes ☐ No (# per day/week) Beer ___/___ Wine ___/___ Liquor ___/___

If quit, when?_____

Sleep Time you normally go to bed _____ Fall asleep_____ Awaken for the day _____

How many hours of sleep do you need to feel rested?_____ How many do you get? _____

Exercise Do you exercise? ☐Yes ☐ No

If so, how often? ☐ Daily ☐ Every other day ☐ Twice per week ☐ Once per week ☐ Rarely

Type of exercise? ☐ Walk ☐ Aerobics ☐ Dance ☐ Run ☐ Bicycle ☐ Team Sports ☐ Yoga ☐ Weight Lift

☐ Other, please specify _____

Emotional State Rate your current daily stress level (0-10) in regard to: _____ Job or school _____
Divorce/Separation/Death _____ Primary relationship _____ Family/Parents/Children _____ Financial

_____ Other, please specify _____

What activities do you engage in to counterbalance stress in your life? _____

_____

Please provide any additional information you feel might be helpful _____

_____

_____