

**\*\*\*\*\*PATIENT REGISTRATION\*\*\*\*\***

Please use **black ink** only and print on **one side** of page only.

**Patient Name:**

\_\_\_\_\_  
Last First MI Preferred Name  
Male / Female Married / Single Child Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Place of Birth: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Residence Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #'s: Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
E Mail Address: \_\_\_\_\_ Home Fax: \_\_\_\_\_  
Are you a full-time student/where? \_\_\_\_\_  
What is the patient's religious or spiritual preference? \_\_\_\_\_

**RESPONSIBLE PARTY**

Name: \_\_\_\_\_ (Circle one): Self / Mother / Father / Legal Guardian  
Address Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #'s: Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
E Mail Address: \_\_\_\_\_ Home Fax: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work: \_\_\_\_\_ Ext: \_\_\_\_\_ Work Fax: \_\_\_\_\_  
Other Parent Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

**APPOINTMENT REMINDER INFORMATION**

May we discuss your medical conditions with anyone? Yes No

If YES, please list below:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

May we phone you to confirm appointments dates and times? Yes No

May we leave a message on your home voice mail? Yes No On your cell voice mail? Yes No

May we leave a message at your place of employment? Yes No

If YES, please name work contact person and/or work phone

Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext.: \_\_\_\_\_

**EMERGENCY CONTACT**

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Last	First	MI	Preferred
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Gender: M F Relationship To Patient: \_\_\_\_\_  
Address Street: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**REFERRAL INFORMATION**

How were you referred to our office? Another patient Friend Relative Internet Medical Office  
Newspaper School Work Other \_\_\_\_\_  
Name of person or office referring you to our practice: \_\_\_\_\_

**Office Hours: Our office hours and days closed are updated daily on [www.drданharper.com](http://www.drданharper.com). Please check this website.**

**Please do not email or fax the reception staff or Dr. Harper under any circumstances. *Please call.***

**FEE SCHEDULE**

- New Patient Appointments 2 hours (approx.):** \$1,040.00 (If longer than 2 hours the fee increases.)
- Brief Appointment up to 15 minutes:** \$130.00
- Limited Appointment up to 30 minutes:** \$260.00
- Intermediate Appointment up to 45 minutes:** \$390.00
- Extended Appointment up to 1 hour:** \$520.00
- Phone consult (for established patients only):** \$135 per each 15 minutes
- Frequency Specific Microcurrent:** \$95 - \$150
- IV's:** The cost of your custom IV may vary from \$185.00 to \$325.00 or more

**Supplements, BIA analysis or other additional tests are not included in the new patient appointment fees. Charges for these items must be paid on the day of the new patient appointment.**

We accept cash, Visa, MasterCard and Discover. We do not accept American Express.

Fees for young children may be less, as the first new patient appointment is usually, but not always one hour.

**Payment is due in full at time of service.** For each appointment we provide a super bill for submission to insurance companies. We do not bill insurance directly. Also, we do not accept Medicare or TRICARE. Due to normal inflation, prices are subject to change without notice. Other prices shall apply for various procedures.

Please note: We do not accept or cash any type of insurance check and we do not accept any kind of insurance assignment.

Most times, the day before appointments, our receptionist will give a courtesy reminder call to the phone number provided to us, but it is important to note that it is the responsibility of the patient or patient's guardian to remember the appointment date and time.

Please be aware of the need for prescription refills. We require that you notify us at least one week before requiring any refills. If a prior authorization is needed for your prescription refill, please notify us 2 weeks prior.

If you have any type of physical disability or injury, please notify us so we may schedule your appointment in the appropriate examination room. Handicap parking is in the back of the building on the lower level.

### **CANCELLATION AND RESCHEDULING AND POLICY**

**Please arrive at least 10 minutes prior to your scheduled appointment.** All patients please note, the doctor's appointments run back to back and he cannot carry over into the next patient's appointment. If you arrive late you will receive the remaining time left in your appointment and you will be charged for the full fee of your scheduled appointment.

**New Patients:** All new patient forms must be received at our office prior to scheduling first appointment. We prefer that the forms are dropped off at the clinic or mailed to us. Please include any copies of labs or past medical records. We must keep these copies in your chart and can not give them back to you. These documents must be printed out and we will not review labs or documents on any cell phones or computers. If we must make copies, we charge 25 cents per page.

For **new patient appointment cancellations**, we require that the patient or patient's parent or guardian call Be Well Associates **at least 4 days or preferably as soon as possible** before the scheduled appointment.

For IV's we require that the patient or patient's parents or guardian call Be Well Associates at least **48-hours** in advance to cancel or reschedule. **Please note:** IV's are made of a custom mix of ingredients and cannot be used on any other patient. They are mixed each morning for the day. **Therefore patients will be charged for the full cost of the IV if we receive the cancellation or reschedule call after the IV is mixed.**

For **existing patient appointments** call at least **48-hours** before the appointment time to cancel or reschedule. If possible, **more than 48-hours notice is preferable**, so that another patient in need may have your appointment time.

**If we do not receive cancellations or reschedules in the time periods listed above, the patient or patient's guardian will be charged the full cost of the scheduled appointment or procedure.**

**I agree to the above listed cancellation policy. I also agree to pay Be Well Associates for any missed appointments, IV's, phone consults, house calls, hospital visits and balances due on my account or for services, shipping costs, products and supplements. If I request products or supplements to be sent to me I agree to pay Be Well Associates for the items and shipping/handling charge. If my package is stolen from my door, the full cost must be paid to Bell Well Associates. (Please let us know so we may contact the shipper.)**

**Be Well Associates, Inc., APC Dan O. Harper, M.D.**  
509 South Cedros Ave., Suite B, Solana Beach, CA 92075, 858-755-1126

The individual seeking treatment or consultation is not considered a patient until Dr. Harper has completed the new patient appointment. If Be Well Associates staff or Dr. Harper receives new patient forms, lab tests, or medical records this does not constitute a doctor /patient relationship until the new patient appointment is completed. Please initial here. \_\_\_\_\_

**Audio or video taping of any consultations or treatments is strictly forbidden. This includes cell phone voice recording or pictures.**

**I am fully aware that I must pay in full at the first and every appointment. Note, new patient appointments may range from \$1,040 (if only 2 hours) or more, not including supplements, tests, BIA, IV's or medications.**

**I agree to read the Physician Specialist Consent (page 7) carefully and I will ask for any clarification.**

**Please sign below to acknowledge your agreement:**

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If applicable:**

Patient's Legal Representative (Print): \_\_\_\_\_

Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Legal Representative Phone:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**If mailing address is different than residence, please list below:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please note:** You may park on Cedros Ave. but be aware of parking limits as some are 2 hours and only a few are 3 hours. There is also parking behind 509 and 511 Cedros. Our office is on the top floor facing Cedros Ave. You may enter in the center door. Please do not enter or ask for information in the offices on the bottom floor in the back of the building.

**Patient's Request for Non-Medicare Services**

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private contract with a Medicare beneficiary. Signatures from the provider, a witness and the patient/beneficiary or their legal representative are required below. The supplier must submit an affidavit to Medicare expressing his/her decision to opt-out. This agreement is between Dan O. Harper, MD (NPI-1811085244) and ("Patient").

**Patient Name:** \_\_\_\_\_

- I, Dan O. Harper, M.D., have not been excluded from Medicare under sections 1128, 1156, or 1892 of the Social Security Act.
- I (the Medicare beneficiary) or my legal representative accept full responsibility for payment of charges for all services furnished by Dan O. Harper, M.D.
- I (the Medicare beneficiary) or my legal representative understand that Medicare limits do not apply to what Dan O. Harper, M.D. may charge for items or services furnished.
- **I (the Medicare beneficiary) or my legal representative agree not to submit a claim to Medicare or to ask Dan O. Harper, M.D. to submit a claim to Medicare.**
- I (the Medicare beneficiary) or my legal representative understand that Medicare payment will not be made for any items or services furnished by Dan O. Harper, M.D. that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- I (the Medicare beneficiary) or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out. The effective date of the opt-out period is July 1, 2016 and there is no expiration date.
- I (the Medicare beneficiary) or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- I (the Medicare beneficiary) or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.
- This contract cannot be entered into by me, (the Medicare beneficiary), or my legal representative during a time when I, (the Medicare beneficiary), require **emergency care services or urgent care services**. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual).
- I, Dan O. Harper, M.D., understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

**Please sign below to acknowledge your agreement:**

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If applicable:**

Patient's Legal Representative (please print): \_\_\_\_\_

Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Legal Representative Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Medical Office Signature:**

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notification Regarding TRICARE**

This form is to notify you that Dan O. Harper, M.D. is not an authorized provider for patients covered by TRICARE. Please read the following information:

- I (the TRICARE beneficiary) or my legal representative accept full responsibility for payment of charges for all services furnished by Dan O. Harper, M.D.
- I (the TRICARE beneficiary) or my legal representative understand that the TRICARE limits do not apply to what Dan O. Harper, M.D. may charge for items or services furnished.
- I (the TRICARE beneficiary) or my legal representative agree not to submit a claim to TRICARE or to ask Dan O. Harper, M.D. to submit a claim to TRICARE.
- I (the TRICARE beneficiary) or my legal representative understand that TRICARE payment will not be made for any items or services furnished by Dan O. Harper, M.D. that would have otherwise been covered by TRICARE if Dan O. Harper, M.D. were an authorized provider for TRICARE.
- I (the TRICARE beneficiary) or my legal representative understand that I have the right to obtain TRICARE-covered items and services from a physician and/or practitioner who is an authorized provider for TRICARE.
- I (the TRICARE beneficiary) or my legal representative will receive a copy of this form upon request, before items or services are furnished to me under the terms of this contract.

**Please sign below to acknowledge your agreement:**

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If applicable:**

Patient's Legal Representative (print): \_\_\_\_\_

Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Legal Representative Phone:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Physician Specialist Consent**

Be Well Associates, Inc., APC, is a specialty medical clinic and Dan O. Harper, M.D. is serving as a specialist at this clinic for complementary/integrative medical care and nutritional consultation, as well as for chronic and complicated medical cases.

Dan O. Harper, M.D. is board certified in Family Medicine, Lipidology, Environmental Medicine, Holistic Medicine, and Integrative Medicine, as well as a certified Nutritional Specialist with a license and certification in Homeopathy.

As such, Be Well Associates/Dan O. Harper, M.D. does not provide primary medical care.

We require all patients to continue a relationship with a primary medical provider for ongoing routine care, as well as urgent medical problems which may arise while you are being treated at our facility. Your primary care provider would be responsible for any routine cold/flu care, vaccinations, annual physical examinations, and any other routine care normally provided by a primary care physician. Please initial here. \_\_\_\_\_

Primary care physicians typically have hospital admitting privileges and 24-hour coverage for their patients. As a specialty provider, Dan O. Harper, M.D. is not affiliated with and does not have admitting privileges at any area hospital. You should contact your primary care provider for any after-hour emergencies, medical needs, or urgent questions. You are welcome to leave non-emergency messages at any time that will be addressed during the next business day.

**I fully understand and concur with the above statements. I have taken adequate time to consider my decision to seek evaluation and treatment with Dan O. Harper, M.D.**

**Please sign below to acknowledge your agreement:**

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If applicable:**

Patient's Legal Representative (print): \_\_\_\_\_

Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Legal Representative Phone:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Medical Disclaimer**

I, \_\_\_\_\_, have read and agree to the following statements:

- I fully understand that there are no warranties, assurances, or guarantees of successful outcomes.
- There are no claims made of healing or cures.
- Some of the treatments given at the clinic may not be FDA approved, but careful investigation has been done regarding these treatments. I may choose to have some of these treatments after reading the appropriate informed consents and after I have had all have my questions answered by Dr. Harper.
- I am free to stop any treatments at any time without reprisal or condemnation from the clinic staff, or Dr. Harper. I may resume any treatments in the future if I so choose. Such decisions are mine to execute.
- My possessions that I bring to the clinic during evaluation and treatments are my responsibility to care for, and the clinic will not be responsible for any lost or damaged items.
- I will provide supervision for any young children that may accompany me to the clinic, and I will be responsible for any items damaged.
- I will carefully follow the instructions given to me concerning my treatments and any equipment used in such treatments, understanding that any injuries resulting from not following those instructions will be my responsibility. I will not hold the clinic liable in any form.
- I understand that many of the clinic's staff and clients are chemically sensitive. **I will refrain from wearing colognes, perfumes, fragrances or scented hair products on the days I enter Be Well Associates.** If I unknowingly forget this, my appointments may have to be rescheduled for another day and the full charge for the scheduled appointment may be charged to me.
- I have also been informed that the World Health Organization has declared Cell Phone use to be a Class 2B carcinogen. The harmful microwave frequencies generated by my cell phone, even if on vibration or airplane mode, may be harmful to others in the clinic. The cell phone frequencies may also interfere with treatments given in Be Well Associate's treatment room. **I will turn off my cell phone before entering the clinic building.**

**Please sign below to acknowledge your agreement:**

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If applicable:**

Patient's Legal Representative (print): \_\_\_\_\_

Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Legal Representative Phone:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



**Consent for Treatment by Dan O. Harper, M.D.**

I have sought medical care from Dan O. Harper, M.D. I have chosen to do this of my own free will. I am aware that Dr. Harper is board certified as both an allopathic family practice physician and as an integrative/holistic physician. He is also licensed as a homeopathic physician. Allopathic medicine refers to medicine as it is commonly practiced in the United States, a system that uses pharmaceuticals and surgery as the primary modes of therapy. Integrative/holistic medicine refers to a system which uses naturally derived substances such as homeopathic remedies, herbs, vitamins, enzymes, energetic modalities etc. to promote and restore a healthy balance to the body. Since Dr. Harper is dually trained and board certified in both systems, he is qualified to weigh the benefits of traditional allopathic treatments normally available to practitioners of family medicine versus the alternative/holistic, functional modalities that he offers. However, if the patient is in need of care by a specialist outside of the area of family medicine, alternative/holistic, or functional medicine, Dr. Harper would refer the patient to applicable physicians. This would help determine which treatments are in the patient's best interest. Dr. Harper emphasizes the importance of nutrition, exercise, attitude, and non-toxic remedies and supplements as the therapeutic mainstays for restoring a patient to his or her optimal state of health.

I realize that Dr. Harper's integrated approach to medical therapy may not be as rapid as pharmaceutical or surgical therapy. It may require more effort from me than the simple administration of a symptomatic medication for each complaint. Some medical authorities consider such treatment to be unproven and/or ineffective. I also understand that every patient is unique. Dr. Harper cannot warrant or guarantee that his treatment programs will always result in an improvement of the condition being treated.

I also understand that many insurance plans have clauses which limit coverage to usual and customary fees for necessary services. I realize that some of the integrative/holistic medical services provided by Dr. Harper will not fall under this description. I do not hold Dr. Harper responsible for the possible decisions by insurance companies to deny coverage for any of the medical services I may receive at Be Well Associates.

I release and forever discharge Dr. Dan Harper and his heirs, successors, and administrators from all claims, loss, damages, and injuries, present and future, in any manner arising out of my consultations or treatments with him. This release covers all damages, whether or not contemplated at the present time and includes situations undeveloped and unknown at the present time, as well as those now known.

If I choose at any time **not** to have any integrative/holistic medical treatments or any other type of treatment or medical test at Be Well Associates, I will notify Dr. Harper immediately. If explanations for any treatments or tests are not fully understood by me, I will also inform Dr. Harper.

By my signature below I state that I have had adequate time to read and understand the above information:

**Please sign below to acknowledge your agreement:**

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If applicable:**

Patient's Legal Representative (print): \_\_\_\_\_

Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Legal Representative Phone:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Acknowledgment of Receipt of HIPAA Privacy Practices**

We at Be Well Associates Inc., APC are required by law to maintain the privacy of individuals and provide individuals with our Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our Office Manager in person or by phone at our number above. If you would like a copy of our entire HIPAA Privacy Practices, please ask. Our Privacy Policy is also on our website at [www.drphanharper.com](http://www.drphanharper.com).

Patient Name (print): \_\_\_\_\_

Patient (sign): \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**If applicable:**

Patient's Legal Representative (print): \_\_\_\_\_

Patient's Legal Representative (sign): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**NOTICE TO CONSUMERS**

Medical doctor, Dan O. Harper, M.D. of Be Well Associates, is licensed and regulated by the Medical Board of California. (800) 633-2322 www.mbc.ca.gov

By signing this document, I hereby acknowledge that I have read and understand the above-referenced notice.

Patient name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If applicable:

Patient's Legal Representative (print): \_\_\_\_\_

Patient's Legal Representative (sign): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

## Health Appraisal Questionnaire

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medication allergies (if none, please write in none): \_\_\_\_\_

Reason for this health consultation: \_\_\_\_\_

Please list occupations or jobs, current and past (to show possible toxic exposures at work): \_\_\_\_\_

1. Please check (✓) all of the conditions which you now have or have been treated for in the past:		
Diabetes mellitus	Pneumonia	Parkinson's Disease
Hypo/ hyperglycemia	Glaucoma	Diverticulitis/ diverticulosis
Elevated cholesterol	Macular Degeneration- wet/ dry	Inflammatory Bowel Disease
Elevated triglycerides	Food intolerances/ allergies	Irritable Bowel Syndrome
Emphysema/ COPD	Hayfever/ airborne allergies	Ulcerative Colitis
Asthma/ Reactive Airway Disease	Headaches- tension/ migraine	Crohn's Disease
Pulmonary Hypertension	Sleep Apnea	Lupus
Cardiac arrhythmias-A.fib/ PVC's	Insomnia/ sleep disorders	Rheumatoid Arthritis
Heart Attack/ coronary artery dis.	Depression	Osteoarthritis
Heart Valve –aortic/ mitral/tricuspid	Anxiety	Other Autoimmune Disorders
Angina—chest pains	ADD/ ADHD	Immune Deficiencies
High blood pressure	Bipolar	Cancer: _____
Stroke/ TIA (mini-stroke)	Obsessive compulsive disorder	HIV/ AIDS
Varicose Veins	Alzheimer's / dementia	Lyme Disease
Anemia— type: _____	Osteoporosis / osteopenia	Recurrent Infection: _____
Chronic Fatigue Syndrome	Paget's Disease	Females: Endometriosis
Fibromyalgia	Thyroid disease—hyper/ hypo-	Post-partum blues
Multiple Chemical Sensitivities	Gallbladder disease/ gallstones	Fibroids
Mold Sensitivity/ Infection	Liver Disease	Polycystic Ovary Disease
Electromagnetic Field Sensitivity	Kidney failure	Hormonal Imbalance
Obesity	Kidney stones	Males: Erectile Dysfunction
Epilepsy/ Seizures	Multiple sclerosis	Benign Prostatic Hypertrophy
Meningitis/ Encephalitis	ALS	Other: _____

Type of your delivery: ( ) Vaginal or ( ) C Section/ Complications? ( ) Yes, or ( ) No/ Breast fed: ( ) Yes, or ( ) No

<b>2. Do you have any close relatives with any of the following health conditions? Please check (√) if "yes".</b>			
Asthma/ severe hay fever	Drug/ Alcohol Addiction	Diabetes: __ childhood / __ adult onset	
Eczema/ psoriasis	Emphysema/ COPD	Multiple Sclerosis/ Parkinson's	
Arthritis/ Rheumatism	Cystic Fibrosis	Autism	
Thyroid disease	Heart Disease	Autoimmune diseases	
Depression/ mental disorder	Stroke/ TIAs	Cancer: type _____	
Alzheimer's dementia	Thrombophlebitis /blood clots	Other: _____	
Did any of these relatives have a heart attack (myocardial infarction) or stroke before age 65? ( ) yes / Before age 55? ( ) yes			

<b>3. Have you been hospitalized in the last five years?</b>	<b>For surgery?</b> Type-
<b>For Infections?</b> Type-	<b>For illness?</b> Type-
<b>For injuries?</b> Type-	<b>For mental health?</b>

<b>4. Pregnancy / Delivery:</b> (Females only)	<b>Complications of pregnancy or delivery:</b> ( ) C-section; ( ) Pre-eclampsia; ( ) Gestational Diabetes; Other: _____
Number of pregnancies : ___ / How many: term births ___, premature births ___, still-born ___ miscarriages ___, surgical abortions ___	
Number of living children: _____	Number of children still at home: _____

<b>5. Types of known infections from past—check (√) those that you know you have had or been treated for--</b>					
Mono/ EBV	Hepatitis A	Mycoplasma	Lyme: Bartonella	Anthrax	
Herpes simplex	Hepatitis B	Chlamydia	H. pylori	Mumps	
Her. zoster /shingles	Hepatitis C	Gonorrhea	Giardiasis or Ameba	Malaria	
CMV	HIV	Lyme: Borrelia	Rocky Mt. Spotted Fever	Candida (yeast)	
HHV 6 or HHV 7	HPV				
Coxsackie virus	Polio	Lyme: Babesia	Q Fever	Tuberculosis	
West Nile Virus	Strep throat	Lyme: Ehrlicia	Brucellosis	Other:	

<b>6. Types of surgeries you have ever had performed: (check (√) all that apply). Also indicate year of surgery if known.</b>					
Tonsillectomy	Bilateral Tubal Ligation	Fibroid removal	Stomach Banding	Bone Plate or ORIF	
Appendectomy	Vasectomy	Hysterectomy-?ovary	Stomach Stapling	Neck Surgery	
Gallbladder	Knee Replacement	Hemorrhoidectomy	Thyroid Nodule	Lumbar surgery	
CABG (heart)	Hip Replacement	Vein Stripping	Thyroidectomy	Harrington Rod	
Heart stent	Laser Eye Surgery	Stomach Ulcer Surgery	Vessel Bypass or Stent in artery not in heart	Breast Implants/ Augmentation	
Cataract—R / L	Lasix Eye Correct	Whipple Procedure		Other:	

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7. Significant Traumas: (check (√) all that apply). Also indicate year of trauma if known—such as “04”		
Motor Vehicle Accident	Head injuries	Gunshot Wound
Motorcycle Accident	Bicycle Accident	Stabbing
Significant fall	Sports Injury	Molestation/ Rape
Second or third degree burns	Physical Assault / Abuse	Other:

8. Stress Questions: In the last year, have you had any of the following? (check (√) all that apply).		
Death of a spouse	Change in Level of Faith	Troubles with spouse
Divorce	Loss of Job	Foreclosure of a loan
Marital Separation	Retirement	Change in job description
Legal Troubles	Illness of a Family Member	Child leaving home
Molestation/ Rape	Pregnancy	Trouble with in-laws
Death of a Family Member	Sexual Difficulties	Teenager problems
Loss of Self-Confidence	Addition of a new family member	Change in sleep habits
Personal Injury or Illness	Loss of a close friend	Change in residence
Marriage	Changed Line of Work	Tension at workplace

9. Stress Reduction: What do you do to reduce the above stress? (check (√) all that apply).		
Exercise	Comfort foods/ binge eating	Laughter/ joking around
Biofeedback	Gardening	Massage
Crying	Hiking	Music—listening or playing
Dancing	Rest/ get lots of sleep	Reading
Talking to friend or fellow employee	Hobby:	Prayer
Eating healthy	Hot tub or hot shower	Other:

10. Immunizations: check (√) all that you have been vaccinated for and indicate approximate dates:		
MMR-measles/mumps/rubella	Hepatitis A	Pneumococcal
Polio	Hepatitis B	Influenza
Smallpox	Yellow Fever	Tetanus
Chickenpox/ shingles	Dengue Fever	Cholera
Meningococcal	Typhoid	Covid/Other:

*Please indicate if you or any family members have had vaccine reactions...*

11. Examinations: (please write in the year of last exam in the blank---i.e. 1997)		
___ Complete Physical Examination	___ Ultrasound	___ Dental Exam
___ EKG	___ C.T. Scan	___ Eye Exam
___ Lab panel	___ MRI or PET scan	___ Other:
___ Chest X-ray	<i>If female:</i> ___ PAP	
___ Colonoscopy	___ Mammogram	<i>If male:</i> ___ PSA blood test
___ Cardiac Stress Test	___ Thermography of Breasts	___ Prostate Exam

*Please bring in copies of the final reports of any significant positive tests...*

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12. Environment Influences: (check (√) all that apply). Circle all that are problematic.					
Mold/ black fungus	Dental Implants	Printing press fumes	Near high power lines	Remodeling home	
Loud noises	Chlorine	HVAC ducts-old	Near cell phone tower	Remodeling work	
Pesticides	Fluoride	Solvents	Near drilling well	Pets indoor home	
Radiation from X-ray	Dust	Paint / varnish fumes	New carpets	Cigarette smoke	
EMFs/ wi-fi--microwave	Car Exhaust	Asbestos	Cleaning solutions	Car or home air fresheners	
Mercury Amalgams	Diesel Exhaust	Mining operations	Concussion	Vaping	
Root Canals	Gasoline fumes	Lead pipes/ paints	Post-Traumatic Stress	Other:	
List any <u>specific</u> chemicals at work or home that you know are causing reactions:					

14. Residence: (check (√) all that apply).				
Live in single family home	Dwelling in suburban area	Dwelling is over 25 years old	House has central air	
Live in mobile home	Dwelling in rural area	Use humidifier in home	House has central vacuum	
Live in condo	Dwelling newly built	Use air conditioner in home	Heating system is oil	
Live in rental apartment	Dwelling is newly remodeled	Use air conditioner work	Heating system is coal	
Live in car or tent	Dwelling 3-10 years old	Use air conditioner in bedroom	Heating system is electric	
Dwelling in city	Dwelling is 11-25 years old	Use air conditioner in car	Heating is wood burning	

15. Bedroom Environment: (check (√) all that apply).				
Mattress is:	Pillow is:	Flooring:	Items near head at night while sleeping:	
Feather	Feather	Hardwood	Cell phone	
Memory foam	Dacron	Carpet	Plugged in alarm clock/ lamp near bed	
Horse hair	Memory Foam	Stone or tile	Computer or wi-fi equipment	
Organic cotton/wool	Foam rubber	Linoleum	TV or stereo speakers- ---corded or remote	
Do you have allergy control products on the pillows, mattress and box springs? ( ) yes / ( ) no				

16. Tobacco Exposure: (check (√) all that apply).			
a. Have you been exposed to tobacco smoke? ( ) at home, ( ) at work, ( ) in stores, ( ) while in car, ( ) place of worship			
b. Did you experience second hand cigarette or cigar smoke while growing up? ( ) yes, number of years____; ( ) no			
c. Do you personally smoke cigarettes or vape now? ( ) yes, number of packs per day___/ number of years____; ( ) no			
d. Do you personally smoke cigars? ( ) yes, ___ years ( ) no; smoke pipe? ( ) yes, ___# times/day, ___ years, ( ) no			
e. Do you currently use or have you used chewing tobacco? ( ) yes, ___cans per week, ___#years; ( ) no, never have ☺			
With smoke fumes you experience: (check (√) all that apply).		Headache	Nausea
Fast Heart Beat	Shortness of breath	Wheezing	Other:_____

<b>17. Mold Exposure:</b> If you have any symptoms in the presence of mold, please indicate below: (check (√) all that apply).			
Muscle Aches	Headache	Irritability	Laryngitis
Joint Pains	Bloating/ gas	Visual Changes	Nausea
Fatigue/ Weakness	Heartburn/Indigestion	Chest tightness	Skin Rashes
Memory Issues	Shortness of Breath	Insomnia	Tremors
Cognitive Issues	Anxiety	Dizziness	Heart Palpitations
Sinusitis	Depression	Numbness/tingling	Onset of Fibromyalgia

Have you received frequent courses of antibiotics? ( ) Yes, ( ) No/ Ever received ( ) Cipro ( ) Levaquin?

<b>18. Electro-Magnetic Field Exposure:</b> If you have symptoms in the presence of EMF's: (check (√) all that apply).			
Localized tingling	Swollen mucous membranes	Tachycardia	Sensitivity to light/ glare
Localized heat	Dry eyes	Dizziness on rising	Burning Skin
Headache	Muscle Aches	ringing in the ears	Tremors
Brain fog	Joint Aches	Insomnia	Blushing/ red face
Nausea	Heart Palpitations	Sensitivity to Noise	Other:

<b>19. Chemically Sensitive:</b> please indicate which of the following are true today in your present condition: (check (√) all that apply).	
<input type="checkbox"/>	a. Symptoms are reproducible with repeated (chemical) exposures.
<input type="checkbox"/>	b. The condition has persisted for a significant period of time.
<input type="checkbox"/>	c. Low levels of exposure (lower than previously or commonly tolerated) result in manifestations of the syndrome (i.e. increased sensitivity).
<input type="checkbox"/>	d. The symptoms improve or resolve completely when the triggering chemicals are removed.
<input type="checkbox"/>	e. Responses often occur to multiple chemically unrelated substances.
<input type="checkbox"/>	f. Symptoms involve multiple-organ symptoms (runny nose, itchy eyes, headache, scratchy throat, ear ache, scalp pain, mental confusion or sleepiness, palpitations of the heart, upset stomach, nausea and/or diarrhea, abdominal cramping, aching joints).

<b>20. If the issues are predominately related to the skin, please answer the following: (check (√) all that apply).</b>			
<input type="checkbox"/>	Skin itches—worse ( ) night, ( ) heat, ( ) under stress, ( ) in EMFs, ( ) other_____	Things are pushed out through skin— ( ) fibers, ( ) crystals, ( ) 'critters', ( ) plastic threads, ( ) black beads, ( ) pus-like material, ( ) other_____	Skin sloughing or peeling
			Skin cracking and bleeding
<input type="checkbox"/>	Feel things crawling under skin or organs		Brain fog with itching or worse rash
<input type="checkbox"/>	Have tracks or streaks under or on skin		Insomnia from itch or skin pain
<input type="checkbox"/>	Have seen organisms under or on skin	Others in room begin to itch, sneeze, or get rash	Co-infections: ( ) yeast, ( ) skin fungus, ( ) intestinal parasites,
<input type="checkbox"/>	Skin burns or stings or has numbness	Lint floats off skin—color--_____	( ) insect bites,
<input type="checkbox"/>	Skin forms red blisters or hemangiomas	Skin ulcerations	( ) recent travel illnesses, ( ) other-_____

Give brief description of when and how problems in #17, #18, #19 or #20 occurred and how they have progressed to this point—may finish writing on back, if necessary:

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<b>21. If your problems are mostly <u>allergic</u> in nature, please indicate which conditions make them worse: (check (√) all that apply).</b>				
Indoors	Windy Day	Smoke from wood	Milk products	Vegetables
Outdoors	Hot day	Cigarette smoke	Eggs	Wine
At Home	Cold Day	Soap powder	Soy products	Beer
At Work	Air Conditioning	Insecticides	Wheat/gluten	Hard liquor
In car	In Barns	Paint fumes	Nuts	Cheese
Morning	Damp Areas	Perfumes	Beans or seeds	Mushrooms
Afternoon	Hay, mown grass	Cosmetics	Chocolate	Other food:
At Night	Dusty areas	Wave sets	Fish	Aspirin
Weather change	High Air Pollution	Newspapers/print	Shellfish	NSAIDS
Wet Weather	Animals	Wool	Meats	Drug:
Dry Weather	Cooking Odors	Road Dust	Fruit	Other:
Is there a specific month or months it is worse? ( ) Jan; ( ) Feb; ( ) Mar; ( ) Apr; ( ) May; ( ) Jun; ( ) Jul; ( ) Aug; ( ) Sep; ( ) Oct; ( ) Nov; ( ) Dec; ( ) Year round				

<b>22. If symptoms are related to the mouth and throat, please indicate which you are experiencing: (check (√) all that apply).</b>			
Mouth pain or burning	Denture/ plate problem	Bleeding / swollen gums	Hoarseness of voice
Mouth sores/ ulcerations	Pus on/ or swollen tonsils	Gum abscess/infection	“Belchy” taste in mouth
Sore tongue	Dry mouth	Loss of taste	Trouble swallowing
“Geographic”/white tongue	Toothaches	Metallic taste	Other: _____

<b>23. If symptoms are related to the nose or nasal passages, please indicate which you are experiencing: (check (√) all that apply).</b>			
Nasal discharge	Nasal dryness	Nasal polyps	Change in sense of smell
Sinus pain	Nasal ulcerations or sores	Septal deviation	Snoring at night
Nasal congestion	Nosebleeds	Septal perforation	Other: _____

<b>24. If symptoms are related to the ears or hearing, please indicate which you are experiencing: (check (√) all that apply).</b>			
Earaches	External ear discharge:	Vertigo (room spinning)	Pressure at elevations
Tinnitus/ ear ringing	Blood from ear	Mold growing in ear canal	Pulsation in ears
Decrease in hearing	Pus from ear	Popping in ears	Other: _____

<b>25. If symptoms are related to the eyes / vision, please indicate which you are experiencing: (check (√) all that apply).</b>			
Blurred vision	Glaucoma	Eye redness	Recent change in vision
Double vision	Cataracts	Eye irritation	Trouble seeing to read
Floater in visual fields	Lazy eye	Eye discharge	Wear glasses/ contacts

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Blind spots in visual fields	Crossed eyes	Blindness: ( )R/ ( )L eye	Other: _____
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**26. If symptoms are related to the brain /nervous system, please indicate which you are experiencing: (check (√) all that apply).**

Seizures/ epilepsy	Nervous/ anxious	Inappropriate fears/phobia	Burning/ pain in nerves
Syncope/ blackouts	Emotional outbursts	Disorientation	Mini-strokes (TIA's)
Tremors	Panic attacks	Rapid mood swings	Stroke (CVA)
Twitching/ tics	Compulsive thoughts or acts	"Seeing things"	Weakness of extremity
Memory loss- short term	Depression/ blues	Hallucinations	Paralysis
Memory loss- long	Seasonal Affective Disorder	Numbness/ tingling	Spinal/ nerve damage
Cognitive issues	Brain fog	Migraines	Restless leg syndrome
Focus issues/ ADD / ADHD	Insomnia/ sleep issues	Headaches	Other: _____

**27. If symptoms are related to the blood or hematological system: (check (√) all that apply) and \_\_\_\_\_ type**

Bleeding tendency	Anemia _____	Hemangiomas	Platelet disorders
Leukemia	Required transfusion	Heavy menses	Bone marrow problems
Easy bruising	Reynaud's phenomena	Low white count	Other: _____

**28. If symptoms are related to the endocrine system, please indicate which you are experiencing: (check (√) all that apply).**

Heat intolerance	Fatigue	Abnormal thyroid tests	Bone density loss
Cold intolerance	Excessive thirst/ urination	Goiter/ thyroid nodules	Mano/Menopause
Hair loss for no reason	Loss of outer eye brows	Abnormal adrenal studies	Excessive/ unusual sweating
Abnormal hair distribution	Lack of endurance	Loss of libido	Insatiable appetite
Undesired weight gain	Undesired weight loss	Inches not desired	Other: _____

**29. If your symptoms are related to the musculoskeletal system, please indicate which you are experiencing: (check (√) all that apply).**

Sore joints	Gouty attacks	Sciatica /pain into legs	Stiff neck
Swollen joints	Muscle weakness	Scoliosis/ spinal curve	Headache coming from neck
Deformed joints	Painful muscles/fascia	Frozen shoulder	Trigger finger
Stiff joints/limited motion	Loss of coordination	Rotator cuff tear	Bursal swelling on elbow
Muscle spasms/cramps	Herniated discs	Grinding/clicking joints	Other: _____

**30. If your symptoms are related to the kidneys or bladder, please indicate which you are experiencing: (check (√) all that apply).**

Burning on urination	Urinary urgency	Too little urine	Kidney stones
Frequent urination	Interstitial cystitis	Dark or colored urine	Dribbling urine

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Trouble starting urination	Voiding at night	Flank or mid back pain	Foul smelling urine
Urinary incontinence	Too much urine	Blood in urine	Other: _____
<b>31. If your symptoms are related to the stomach or intestines, please indicate which you are experiencing: (check (√) all that apply).</b>			
Change in appetite	Food not digesting	Jaundice or yellow eyes	Vomiting
Heartburn	Mal-absorption	Blood seen in / on stools	Nervous stomach
Belchy taste in mouth in a.m.	Abdominal distention/bloating	Rectal bleeding	Frequent bowel movements
Vomiting blood	Black, tarry stools	Food sticking in esophagus	Worms in stool
Flatus/ extra gas	Food intolerances	Trouble swallowing	Hemorrhoids
Constipation	Pain after eating	Abdominal pain	Rectal pain after BM
Diarrhea	Nausea	Gallbladder problems	Rectal itching
Change in bowel habits	Stomach ulcers	Abdominal cramping	Other: _____

<b>32. If you have symptoms of the heart or blood vessels, please indicate which you are experiencing: (check (√) all that apply).</b>			
Chest pain at rest	Low blood pressure	Heart murmur	Arm or leg numbness
Chest pain with exertion	High blood pressure	Heart valve problem	Thrombophlebitis /clots
Shortness of breath laying	Dizziness on standing	Exertional shortness of breath	Reynaud's phenomena
Leg swelling/ edema	Palpitations	Coldness of feet or hands	Leg sores / ulcers
Rapid heart beats	Hardened arteries in heart	Discolored feet or hands	Other: _____

<b>33. If you have any symptoms of sleep disturbances, please indicate which you are experiencing: (check (√) all that apply)*</b>			
Snore loudly	Someone observed you stop breathing during sleep	Overweight	Neck circumference 15 3/4" (40cm) or larger
Feel tired	High blood pressure	Over 50 years old	Male
*If more than three are checked, a sleep apnea monitor test should be arranged.			

<b>34. If you have symptoms related to the lungs or your breathing, please indicate which ones you are experiencing: (check (√) all that apply).</b>			
Wheezing	Cough	Can't take a deep breath	Shortness of breath
"Rattle" in chest	Chest pain with deep breath	Exposure to tuberculosis	Periods of apnea
Change in sputum	Coughing up blood	Coughing up mucous	Other: _____

**Use this area to further explain any of the symptoms in numbers #24 to #34:**

35. For females only: please indicate which of the symptoms you might be experiencing: (check (√) all that apply).			
Painful periods	Mood changes near period	Dry vaginal area	Fibroids
Headaches around period	Painful intercourse	Bloating at time of period	Breast lumps
Vaginal discharge	Abnormal PAP in past	Vaginal itching	Fibrocystic Breasts
Pain on ovulation	Endometriosis	Hot flashes	Hx of rape or molestation
Breakthrough bleeding	Loss of libido	Ovarian cysts	Other: _____

36. Exercise: Do you exercise at least 4 days a week? ( )-no ( )-yes		Type of exercises:	
Walking _____ miles	Swimming/ Surfing	Tennis	
Jogging _____ miles	Free weights	Pilates	
Hiking _____ miles	Treadmill	Aerobics	
Biking _____ miles	Golf	other: _____	
Do you exercise to:			
Lose weight	Reduce stress	Increase motivation/ feel good	
Gain weight	Increase strength	Increase flexibility	
Cardiovascular conditioning	Maintain health	Condition for sports	
What limits your physical activity? ( ) injuries listed below, ( ) lack of time, ( ) fatigue, ( ) just not my thing			
Arm / elbow injury	Nerve damage	Groin injury	
Shoulder injury	Wrist / hand injury	Hamstring pull	
Ankle / foot injury	Hip / pelvis injury	Bone spurs	
Recent fracture/ stress fracture	Tennis elbow	Joint disease	
Low back pain	Neck injury	Abdominal pain	
Arthritis	Upper back injury	Dizziness	
Bursitis /calcium deposit	Knee / thigh injury	Chest pain	

37. Foods and Beverages: Think of the meals and snacks that you have had in the last week—indicate in the box how many portions of each you had in that week. Example: for five helpings of brown rice last week-- <input type="text" value="5"/> -brown rice		
Potato—baked, mashed	Ice cream	Beef
Dry cereals	Butter	Pork
Brown rice	Milk	Chicken/ turkey
White rice	Margarine / Veg. Oil	Candy bars/choc.
Rolls / biscuits	Eggs	Chips
White bread	Nuts / nut butter	Sweet snacks
Whole wheat bread	Oatmeal	Soda pop / lemonade
Pasta	Fresh vegetables	Fruit juice
Cakes / pies / pastries	Fresh fruits	Beer
Cottage cheese	Fresh salads	Liquor
Yogurt	Shellfish	Wine
Cheese	Fish	other: _____

<b>Food preparation: total % needs to add to 100% --</b>			
Frozen foods-___%	+Canned foods-___%	+Fresh foods-___%	+Dehydrated foods-___% = to 100% of foods
<b>Most meals are:</b> ( ) at home; ( ) on the road; ( ) fast foods- eat out; ( ) fast foods- take home/delivered; ( ) mooch off family/friends			

<b>38. Life Style Choices: (check (√) all that apply).</b>			
<b>Drink the fluoridated tap water</b>	<b>Live within ½ mile of high power lines</b>	<b>For Women:</b>	
<small>Drink Reverse Osmosis Water*trace minerals added</small>	<b>Live with a mile of cell phone tower</b>	<b>Acrylic nails- non-toxic</b>	
<b>Drink Bottled or Delivered Water</b>	<b>Cell phone receivers on work place</b>	<b>Use wireless bras</b>	
<b>Drink Filtered Water</b>	<b>Cell phone receivers church/mosque</b>	<b>Skin lotions/ natural --non-paraben</b>	
<b>Drink at least 6 glasses of plain water</b>	<b>Use artificial air fresheners at home</b>	<b>Use bio-identical hormone</b>	
<b>Use a microwave to heat food or water</b>	<b>Use artificial car air fresheners</b>	<b>Use hair dyes that are natural</b>	
<b>Use a cell phone or cordless phone</b>	<b>Use scented detergents/fabric softener</b>	<b>Use all natural make up</b>	
<b>Use a router/ wi-fi on home computer</b>	<b>Use artificial cologne or perfume</b>	<b>Use natural hair spray/ mousse</b>	
<b>Sleep with computer router still on</b>	<b>Use antiperspirant: type_____</b>	<b>Avoid talking on cell /texting in car</b>	
<b>Have plugged in alarm clock near head</b>	<b>Use seat belts in car</b>	<b>Use non-synthetic vitamins/minerals</b>	
<b>Sleep with cell phone on</b>	<b>Have a central vacuum in home</b>	<b>Use non-PABA sunscreen</b>	
<b>Have SDGE Smart Meter on home</b>	<b>Have an air filtration unit in home</b>	<b>Use non-sugar/non-fluoridated tooth paste</b>	
<b>Get eight hours or more of sleep/night</b>	<b>Spray pesticides in or near home</b>	<b>Choose non-toxic products</b>	
<b>Get 30+minutes of exercise 4-5days/week</b>	<b>Meditate or relax daily</b>	<b>Recycle when possible</b>	
<b>Focus on positive things</b>	<b>Choose to eat healthy</b>	<b>Have a loving pet/ mate/ friend</b>	
<b>Have 1-2 daily bowel movements</b>	<b>Choose to shop for natural foods</b>	<b>Enjoy the sunshine often</b>	

**What have you done in the last few years to try to improve your health (e.g. other doctors, treatments, massages, acupuncture, craniosacral therapy, chiropractors, etc.)?**

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What areas of your lifestyle are likely involved with your condition and you would like to have improved: (please prioritize #1, 2, 3, etc.)

- |  |  |
|--|--|
| <input type="checkbox"/> my level of anxiety           | <input type="checkbox"/> not enough time spent in nature |
| <input type="checkbox"/> my pace of living             | <input type="checkbox"/> my creative expression          |
| <input type="checkbox"/> not enough peace and quiet    | <input type="checkbox"/> my feelings about my career     |
| <input type="checkbox"/> my diet and nutrition program | <input type="checkbox"/> my social and family life       |
| <input type="checkbox"/> my exercise program           | <input type="checkbox"/> my communications skills        |

What obstacles could prevent you from changing those things in your lifestyle that are undermining your health?

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Other issues or concerns you want addressed:

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List your special interests and passions in life:

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I understand that there are no guarantees in the field of health. I realize that if I am not willing to work towards my health or the health of my loved ones seeking consultation with Dr. Harper, that none of the suggestions made will correct improper diet, unhealthy lifestyle, or years of bad habits. The work is up to me, with Dr. Harper as a consultant and educator. Please initial here. \_\_\_\_\_

List the name of any doctors or practitioners you are currently seeing with brief reason (please list your primary care physician):

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List the name of doctors or practitioners you have seen in the past with brief reason:

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**Please add any other comments or information:** \_\_\_\_\_  
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Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If applicable:**

Patient's Legal Representative (print): \_\_\_\_\_

Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Legal Representative Phone:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_





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**Be Well Associates, Inc./Dan O. Harper, MD**  
509 South Cedros Ave., Suite B, Solana Beach, CA 92075 858-755-1126  
Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Phone #: \_\_\_\_\_

<u><b>Medication Allergies:</b></u>    
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**Medications Prescribed by Other Physicians**

Date Started	Date Ended	Prescription Name/Dose/Purpose	Prescribing Doctor

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Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Phone #: \_\_\_\_\_

**Medication Allergies:**

**List any Over The Counter (OTC) Medications Commonly Used:**

(Example: Tylenol, Aspirin, Milk of Magnesia, 1% Hydrocortisone Cream...)

Date Started	Date Stopped	OTC Product Name	Manufacturer	Strength	Number & times/day	Suggested by:

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Name:

Date of Birth:

VACCINE	APPROXIMATE DATES	CLINIC	VACCINE	APPROXIMATE DATES	CLINIC
Tetanus, Diphtheria, Pertussis (e.g., Tdap, Td)			Influenza		
Hepatitis A			COVID- ( )Pfizer-mRNA ( )Moderna ( ) J&J viral <i>(For Travelers:) Next four on list:</i> <u>Yellow Fever</u>		
Hepatitis B (e.g., Engerix-B, Recombi- vax HB, Haplisav-B, HepA-HepB6)			<u>Denque Fever</u>		
				<u>Cholera</u>	
					<u>Polio</u>
Human Papilloma Virus (HPV2*, HPV4*, HPV9)			Pneumococcal conjugate (PcV13)		
				Pneumococcal (PPSV 23)	
Measles, Mumps, Rubella (MMR)			Herpes Zoster (Shingles)		
				Meningococcal ACWY (MenACWY, MPSV4)	
Varicella (Chickenpox)			Hib (Hemophilus influenza B)		
				Meningococcal B (e.g., Men B)	
Meningococcal B (e.g., Men B)			Other:		

Please make a notation of any type of adverse vaccine reaction you may have had beside that vaccine.

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*Was it reported to the Adverse Database at CDC? Yes ( ) / No ( )*