In-Depth Patient Visits for Dr. Pugh

Thank you for contacting us for an appointment. I enjoy helping patients who have multiple medical issues that may be impacting their health, well-being and quality of life. Our body systems do not function individually, so I believe in taking a holistic approach to your health. Having a detailed history of your medical problems and symptoms can help me put the pieces of the puzzle together. Symptoms that may not seem related sometimes point to one particular cause. More often, there may be several systems that are not quite functioning optimally. Figuring this out can take time, investigation, and experimentation. Some patients require multiple visits over time to figure everything out. Sometimes our plan changes depending on how you respond to treatment. I will try to respect your time, hard-earned money and energy in this process. I enjoy collaborating with patients to determine the treatment plan that is best for them. My recommendations often include diet and lifestyle changes, supplements and, when needed, prescription medications. If you are ready to work together to improve your health, please read the next sections which cover boring details such as payment and paperwork.

I spent ten years in a traditional practice where I only had 10-15 minutes to spend with a patient. When you have strep throat, that's fine, but when you have chronic medical problems, you need someone to listen and think about all of those issues. Having more time to talk to my patients is not only more fulfilling, but it means that I am able to get more clues that can help me know your body. I also believe that it is important that I am available to answer questions along the way and see you for follow-up visits to make sure we reach your goals. My approach means that I take a lot of time reviewing your records, test results and determining your treatment plan. Part of the visit fee reflects this time (usually during my evenings and weekends) and allows me to maintain a practice with fewer patients while still being able to pay rent, bills and staff salaries. We will provide you with a detailed bill with visit codes, and many patients submit this to their insurance for possible reimbursement. If you have an HSA or FSA fund, this money can be used for your visits. If you have concerns about the costs of tests, medications, etc., I will help you determine the most efficient approach.

In order to maximize our time in the office, it is helpful for me to review your information ahead of time. Please return the forms listed below to our office (fax, mail or drop off). Once I review the information, my staff will contact you to schedule your appointment. This process allows us to schedule an adequate amount of time to address your concerns, get a detailed history and develop a plan. A portion of the visit fee will be required to schedule the appointment since I will spend time reviewing your information and entering your history into our system before the appointment. The balance will be due at the time of your visit. Since staff cannot answer questions about complex issues, I find it helpful to schedule a 15-25 minute phone consultation 1-2 weeks after our first visit so that I can answer any further questions and adjust our plan if needed. This will be included in the initial visit fee. Please complete and return the following forms:

--Dr. Pugh's In-depth Patient History Form (the rest of this document)
--General Registration (if you are a new patient)
--Copies of any tests (labs, x-rays, MRIs, etc) that are pertinent to your concerns. General labs done in the last 6-12 months are very useful. If you aren't sure if it is important, go ahead and include it. If you do not have copies, please fill out the Medical Records IN form on the website so we can request these from another provider.
Genetics consults (to review 23and Me data)—please review the Genetics Consult Information form on the website to send us the correct report

In-Depth Patient History for Dr. Pugh at Central Family Practice

Name:_____ _____ _____ DOB_____ Sex: M F
(First) (Last) (Preferred)

DO NOT LEAVE THIS ITEM BLANK: Narrate your symptoms. _____
_____
_____
_____

Past Medical History—Please **circle** if you currently have, or have a significant history of the following (brief details are all that are needed, as I will clarify questions at your visit):
General: Chronic fatigue Intermittent fatigue Weight gain Weight Loss How many pounds?_____
Fevers Chills Night Sweats Trouble going to sleep Trouble staying asleep Daytime drowsiness

Eyes: Glaucoma Dry eye Uveitis Episcleritis Cataracts Surgery and dates:_____
Other eye issues:

Allergies: Seasonal Year-round Hives Aspirin allergy Latex allergy Nasal polyps Mold exposure
Medication allergies:
Food allergies:

Heart: Chest pain Heart racing Irregular heartbeat Trouble breathing when lying down High cholesterol
High blood pressure Heart murmur Heart attack Stent Stroke Varicose veins Blood clots
Other heart issues:

Lungs: Shortness of breath Chronic cough Chronic sputum (phlegm) Dry cough Pneumonia
Frequent bronchitis COPD/emphysema Exposure to tuberculosis Exposure to Asbestos
Asthma: Childhood Chronic Occasional Ever hospitalized? Y/N Ever intubated? Y/N Currently use inhaler or other asthma med? Y/N If so, what brand(s):
Other Lung issues:

GI: Abdominal pain: Left/Right/Upper/Lower/Middle Cramping Vomiting Bloating Loose stool
Watery stool Hard stool Clay-colored stool Bloody stool Mucous in stool Excessive gas Burping
Acid reflux/heartburn Trouble swallowing Stool urgency Intestinal infection/parasite Celiac disease
Irritable bowel syndrome Crohn's disease Ulcerative Colitis Gallbladder problems: surgery? Y/N
Have you had an endoscopy? Yes/No Date_____ Have you had a colonoscopy? Yes/No Date_____
How often are your bowel movements? #_____per day/week Hemorrhoids Other stomach issues:

Kidneys/bladder: Burning with urination Difficult to urinate Chronic urine frequency Chronic bladder pain
Blood in urine Urine urgency Kidney stone Frequent urine infections: #_____ per year
Other kidney/bladder:

Skin: Frequent rashes Itching Psoriasis Rosacea Eczema Frequent boils/abscesses Nail problems
Skin cancer? Type:_____When:_____ Skin Cancer screening? Yes/no Date:_____
Other Skin:

Name:_____ Date of birth:_____

Musculoskeletal: Joint pain Joint stiffness Joint swelling Joint redness Hot joints Muscle pain
Bone pain Muscle fatigue Muscle cramps Muscle twitches Muscle weakness Osteoporosis/Osteopenia
Osteoarthritis (general wear and tear) Rheumatoid arthritis Gout Lupus
Other musculoskeletal:

Neurological: Headaches (if frequent, please complete headache history form) Numbness Tingling
Vision problems Hearing problems Memory problems Foggy headed MS Epilepsy
Other neurological disease:

Endocrine: Diabetes Hypothyroid Hashimoto's Hyperthyroid/Graves Adrenal problem Intolerant to cold
Intolerant to heat Always thirsty Always hungry Crave sweets Crave salt

Blood/lymph: Swollen lymph glands Easy Bruising Anemia Platelet disorder Blood clot
Infections: HIV Hepatitis A/B/C Syphilis Gonorrhea Chlamydia Herpes: Cold sores/Genital
Chicken pox Shingles Mono/Epstein Barr Chronic yeast infections HPV/Genital warts
Cancer (where/when?):

Psych: Depression Anxiety Panic attacks Bipolar Schizophrenia Ever hospitalized? Y/N
History of sexual abuse History of physical abuse History of mental/emotional/other abuse

Men: Trouble getting erection Trouble maintaining erection Low sex drive Nighttime urination

Women: Irregular periods Heavy periods PMS Menopause/Perimenopause Last menstrual period:
Number of times pregnant: ____ Miscarriages/abortions: ____ Number of live births: ____
Breast pain Discharge from nipples Breast lump (undiagnosed) Vaginal pain Vaginal discharge
Vaginal itching Hot flashes Vaginal dryness Low sex drive
Date of last: Pap:_____ Mammogram: _____ Bone density: _____

Surgeries: Tonsillectomy Adenoidectomy Appendectomy Gallbladder removal (cholecystectomy)
Thyroid surgery: Partial/Full Hysterectomy: uterus only/uterus and ovaries removed Reason:_____
Hernia repair: list site and date
Orthopedic surgery: list site and date
Other:

Any other conditions not listed?

Name:_____ Date of birth:_____

Childhood history:

Any problems at birth or in childhood? (surgeries, infections, birth defects)

Did you have antibiotics more than 3 times in childhood? Yes/No

Social history:

Alcohol intake: None <5 drinks per year <5 drinks per month <7 drinks per week
7-14 drinks per week >14 drinks per week Are you concerned about your drinking?

Smoking/Tobacco: Current smoker/tobacco user? Yes/No Type: Cigarettes/E Cig/Smokeless

If yes, how many per day? Interested in quitting? Yes/No

Past smoker? Yes/No Year started using: _____ Year Quit: _____

Any use of the following? Marijuana Cocaine IV drugs Inappropriate prescription use Other:_____

Do you exercise? Yes/No How many times per week? _____ Activities:_____

Are you exposed to any chemicals or toxins at home, work or during hobbies?

Anything we need to know about stress, home situation, etc?

Diet:

Do you follow any particular diet? Vegetarian Vegan Pescatarian Gluten Free Dairy Free Other:_____

Do you: Drink Milk Drink soy milk Drink Almond Milk Eat soy Eat sugar/sweets often

Do you cook? Yes/No Are you open to trying diet changes? Yes/No

Do you avoid any foods for religious or other reasons?

How often do you eat out? Number of days per week_____

How many fruits/vegetables do you have per day? _____

Do you drink soda? Yes/No If yes, # per week: _____ Regular or Diet sodas _____

Do you have a history of eating disorder or unhealthy eating habits? Yes/No

Do you have problems with any particular foods? (List food and reaction)

Name:_____ Date of birth:_____

Family History: Please list any known medical conditions for each family member. All things are important, but be sure to include cancers (including type), heart attacks (age it occurred, stents, bypass surgery, etc.), strokes, diabetes, blood clots, autoimmune diseases, genetic diseases, mental health issues, etc. A detailed history is useful (if known), so please use back if more space needed. If deceased, please state so and list age of death.

Mom: Dad:

Brother(s): Sister(s):

Maternal grandmother: Paternal grandmother:

Maternal grandfather: Paternal grandfather:

Aunts/uncles: Aunts/uncles:

If you see any specialists on a regular basis (cardiologist, allergist, etc.) please list their name and specialty:

I often recommend vitamins and other supplements in my treatment recommendations. Supplements are not regulated by the FDA, and can vary between manufacturers. I believe that good quality supplements can augment other treatments and can sometimes treat conditions for which we do not have prescription options. Are you open to the use of supplements in your treatment? (Circle One)

Definitely, I prefer them to prescriptions Yes, whatever is best Maybe No, they make expensive urine

Name:_____ Date of birth:_____

Medications/supplements: Please list all prescription and non-prescription medications. OK to list on separate page if needed, but please include all information. No need to list dose of combination supplements. Make note of any specific information (brand needed, etc.). Also list medications that you take as needed (headache medication, allergy medication, etc.)

Name (For supplements, list name and manufacturer)	Dose	Number of pills	Times per day

If you take a lot of supplements, it is most helpful if you bring the actual bottles to your appointment so we can look at all of the ingredient lists together to avoid duplication