FMG Health Questionnaire

MEDICAL QUESTIONNAIRE

ALLERGIES	
Medication/Supplement/Food	Reaction
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

HEALTH CONCERNS

What do you hope to achieve in your visit with us?

____

____

If you had a magic wand and could erase three problems, what would they be?

1. ____
2. ____
3. ____

When was the last time you felt well?

____

____

Did something trigger your change in health?

____

____

What makes you feel worse?

____

____

What makes you feel better?

____

____

FMG Health Questionnaire

Please list current on ongoing problems in order of priority:

Describe Problem	Current/Prior Treatment
Example: Post Nasal Drip	Elimination Diet

Medical History

DISEASES/DIAGNOSIS/CONDITIONS Check appropriate box & **provide date of onset**

Check ❑ for ongoing issue and ❑ for past condition

GASTROINTESTINAL			GENITAL AND URINARY SYSTEMS		
❑	❑	Irritable Bowel Syndrome ____________	❑	❑	Kidney Stones ____________
❑	❑	Inflammatory Bowel Disease ____________	❑	❑	Gout ____________
❑	❑	Crohn's ____________	❑	❑	Interstitial Cystitis ____________
❑	❑	Ulcerative Colitis ____________	❑	❑	Frequent Urinary Tract Infections
❑	❑	Gastritis or Peptic Ulcer Disease ____________	❑	❑	Frequent Yeast Infections ____________
❑	❑	GERD ____________	❑	❑	Erectile or Sexual Dysfunction ____________
❑	❑	Celiac Disease ____________	❑	❑	Other ____________
❑	❑	Other ____________			
CARDIOVASCULAR			**MUSCULOSKELETAL/PAIN**		
❑	❑	Heart Attack ____________	❑	❑	Osteoarthritis ____________
❑	❑	Other Heart Disease ____________	❑	❑	Fibromyalgia ____________
❑	❑	Stroke ____________	❑	❑	Chronic Pain ____________
❑	❑	Elevated Cholesterol ____________	❑	❑	Other ____________

FMG Health Questionnaire

☐	☐	Arrhythmia (irregular heart rate) ____________________
☐	☐	Hypertension (high blood pressure) ____________________
☐	☐	Rheumatic Fever ____________________
☐	☐	Mitral Valve Prolapse ____________________
☐	☐	Other ____________________

METABOLIC/ENDOCRINE

☐	☐	Type 1 Diabetes
☐	☐	Type 2 Diabetes
☐	☐	Hypoglycemia
☐	☐	Metabolic Syndrome ____________________ (Insulin Resistance or Pre-Diabetes)
☐	☐	Hypothyroidism (low thyroid) ____________________
☐	☐	Hyperthyroidism (overactive thyroid) ____________________
☐	☐	Endocrine Problems ____________________
☐	☐	Polycystic ovarian Syndrome (PCOS) ____________________
☐	☐	Infertility ____________________
☐	☐	Weight Gain ____________________
☐	☐	Frequent Weight Fluctuations ____________________
☐	☐	Bulimia ____________________
☐	☐	Anorexia ____________________
☐	☐	Binge Eating Disorder ____________________
☐	☐	Night Eating Syndrome ____________________
☐	☐	Eating Disorder (non-specific) ____________________
☐	☐	Other ____________________

INFLAMMATORY/AUTOIMMUNE

☐	☐	Chronic Fatigue Syndrome ____________________
☐	☐	Autoimmune Disease ____________________
☐	☐	Rheumatoid Arthritis
☐	☐	Lupus SLE
☐	☐	Immune Deficiency Disease
☐	☐	Herpes-Genital
☐	☐	Severe Infectious Disease
☐	☐	Poor Immune Function (frequent infections) ____________________
☐	☐	Food Allergies ____________________
☐	☐	Environmental Allergies ____________________
☐	☐	Multiple Chemical Sensitivities ____________________
☐	☐	Latex Allergy ____________________
☐	☐	Other ____________________

RESPIRATORY DISEASES

☐	☐	Asthma ____________________
☐	☐	Chronic Sinusitis ____________________
☐	☐	Bronchitis ____________________
☐	☐	Emphysema ____________________
☐	☐	Pneumonia ____________________
☐	☐	Tuberculosis ____________________
☐	☐	Sleep Apnea ____________________
☐	☐	Other ____________________

FMG Health Questionnaire

CANCER			SKIN DISEASES		
❑	❑	Lung Cancer ______	❑	❑	Eczema ______
❑	❑	Breast Cancer ______	❑	❑	Psoriasis ______
❑	❑	Colon Cancer ______	❑	❑	Acne ______
❑	❑	Ovarian Cancer ______	❑	❑	Melanoma ______
❑	❑	Prostate Cancer ______	❑	❑	Skin Cancer ______
❑	❑	Skin Cancer ______	❑	❑	Other ______
❑	❑	Other ______	❑	❑	

NEUROLOGIC/MOOD					
❑	❑	Depression ______	❑	❑	Autism ______
❑	❑	Anxiety ______	❑	❑	Mild Cognitive Impairment ______
❑	❑	Bipolar Disorder ______	❑	❑	Memory Problems ______
❑	❑	Schizophrenia ______	❑	❑	Parkinson’s Disease ______
❑	❑	Headaches ______	❑	❑	Multiple Sclerosis ______
❑	❑	Migraines ______	❑	❑	ALS ______
❑	❑	ADD/ADHD ______	❑	❑	Seizures ______
			❑	❑	Other Neurological Problems ______

Preventive Test and Date of Last Test

Check box if yes and provide date

❑	Full Physical Exam	❑	Hemoccult Test - stool test for blood
❑	Bone Density	❑	MRI
❑	Colonoscopy	❑	CT Scan
❑	Cardiac Stress Test	❑	Upper Endoscopy
❑	EBT Heart Scan	❑	Upper GI Series
❑	EKG	❑	Ultrasound

FMG Health Questionnaire

Surgeries

Check box if yes and provide date of surgery

❑	Appendectomy ______________________	❑	Joint Replacement - Knee/Hip __________________
❑	Hysterectomy +/- Ovaries ______________	❑	Heart Surgery - Bypass Valve __________________
❑	Gall Bladder _______________________	❑	Angioplasty or Stent _________________________
❑	Hernia ____________________________	❑	Pacemaker ______________________________
❑	Tonsillectomy _______________________	❑	Other __________________________________
❑	Dental Surgery ______________________	❑	None __________________________________

Injuries

Check box if you have had one of these injuries

	Back Injury
	Head Injury
	Neck Injury
	Broken Bones
	Other ____________________________________

Blood Type

❑	A		❑	Rh-
❑	B		❑	Rh+
❑	AB		❑	Unknown
❑	**O**			

FMG Health Questionnaire

FAMILY HISTORY

Check Family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

FMG Health Questionnaire

Do you notice a tolerance to alcohol (can you "hold" more than others)? ❑ Yes ❑ No

Have you ever been unable to remember what you did during a drinking episode? ❑ Yes ❑ No

Do you get into arguments or physical fights when you have been drinking? ❑ Yes ❑ No

Have you ever been arrested or hospitalized because of drinking? ❑ Yes ❑ No

Have you ever thought about getting help to control or stop your drinking? ❑ Yes ❑ No

OTHER SUBSTANCES

Caffeine Intake: ❑ Yes ❑ No I Coffee cups/day: ❑ 1 ❑ 2-4 ❑ > 4 I Tea cups/day: ❑ 1 ❑ 2-4 ❑ > 4

Caffeinated Sodas or Diet Sodas Intake: ❑ Yes ❑ No

12-ounce can/bottle ❑ 1 ❑ 2-4 ❑ > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): ___________________________

Are you currently using any recreational drugs? ❑ Yes ❑ No

Type _____________________________________

Have you ever used IV or inhaled recreational drugs? ❑ Yes ❑ No

EXERCISE

Current Exercise Program

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ❍ Low ❍ Medium ❍ High

List problems that limit activity: ——____

____

Do you feel unusually fatigued after exercise? ❑ Yes ❑ No

If yes, please describe:

____

____

Do you usually sweat when exercising? ❑ Yes ❑ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ❑ Yes ❑ No

Are you happy? ❑ Yes ❑ No

Do you feel your life has meaning and purpose? ❑ Yes ❑ No

Do you believe stress is presently reducing the quality of your life? ❑ Yes ❑ No

Do you like the work you do? ❑ Yes ❑ No

Have you ever experienced major losses in your life? ❑ Yes ❑ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ❑ Yes ❑ No

Would you describe your experience as a child in your family as happy and secure? ❑ Yes ❑ No

FMG Health Questionnaire

STRESS/COPING

Have you ever sought counseling? ❏ Yes ❏ No

Are you currently in therapy? ❏ Yes ❏ No Describe: ____

Do you feel you have an excessive amount of stress in your life? ❏ Yes ❏ No

Do you feel you can easily handle the stress in your life? ❏ Yes ❏ No

Daily Stressors: Rate on scale of 1-10

Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? ❏ Yes ❏ No How often? _____

Check all that apply: ❏ Yoga ❏ Meditation ❏ Imagery ❏ Breathing ❏ Tai Chi ❏ Prayer ❏

Other: _________

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ❏ Yes ❏ No

SLEEP/REST

Average number of hours you sleep per night: ❏ >10 ❏ 8-10 ❏ 6-8 ❏ < 6

Do you have trouble falling asleep? ❏ Yes ❏ No

Do you feel rested upon awakening? ❏ Yes ❏ No

Do you have problems with insomnia? ❏ Yes ❏ No

Do you snore? ❏ Yes ❏ No

Do you use sleeping aids? ❏ Yes ❏ No Explain: ____

ROLES/RELATIONSHIP

Marital status ❏ Single ❏ Married ❏ Divorced ❏ Gay/Lesbian ❏ Long Term Partnership ❏ Widow

List Children: Child’s Full Name	Age	Gendre

FMG Health Questionnaire

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months:

GENERAL
- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS
- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL
- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness

Muscle Twitches:
  - ☐ Around Eyes
  - ☐ Arms or Legs

- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

Difficulty:
  - ☐ Concentrating
  - ☐ With Balance
  - ☐ With Thinking
  - ☐ With Judgment
  - ☐ With Speech
  - ☐ With Memory

- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pastas)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums

Bloating of:
  - ☐ Lower Abdomen
  - ☐ Whole Abdomen
  - ☐ Bloating After Meals

- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:
  - ☐ Lactose
  - ☐ All Dairy Products
  - ☐ Wheat
  - ☐ Gluten (Wheat, Rye, Barley)
  - ☐ Corn
  - ☐ Eggs
  - ☐ Fatty Foods
  - ☐ Yeast

- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

FMG Health Questionnaire

SKIN PROBLEMS
- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN
- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF
- ☐ Eyes
- ☐ Feet
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Hair
  - ☐ And Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Any Dandruff?
- ☐ Skin In General

LYMPH NODES
- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:
  - ☐ Fingernails
  - ☐ Toenails
- ☐ White Spots/Lines

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever:
  - ☐ Spring
  - ☐ Summer
  - ☐ Fall
  - ☐ Change Of Season
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY
- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE
- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:
  - ☐ Bloating Breast Tenderness
  - ☐ Carbohydrate Cravings
  - ☐ Chocolate Cravings
  - ☐ Constipation
  - ☐ Decreased Sleep
  - ☐ Diarrhea
  - ☐ Fatigue
  - ☐ Increased Sleep
  - ☐ Irritability

Menstrual:
  - ☐ Cramps
  - ☐ Heavy Periods
  - ☐ Irregular Periods
  - ☐ No Periods
  - ☐ Scanty Periods
  - ☐ Spotting Between

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet . . . .◎ 5 ◎ 4 ◎ 3 ◎ 2 ◎ 1

Take several nutritional supplements each day. . . . .◎ 5 ◎ 4 ◎ 3 ◎ 2 ◎ 1

Keep a record of everything you eat each day . . . .◎ 5 ◎ 4 ◎ 3 ◎ 2 ◎ 1

Modify your lifestyle (e.g., work demands, sleep habits)…….◎ 5 ◎ 4 ◎ 3 ◎ 2 ◎ 1

Practice a relaxation technique . . . .◎ 5 ◎ 4 ◎ 3 ◎ 2 ◎ 1

Engage in regular exercise . . . .◎ 5 ◎ 4 ◎ 3 ◎ 2 ◎ 1

Have periodic lab tests to assess your progress . . . .◎ 5 ◎ 4 ◎ 3 ◎ 2 ◎ 1

Comments

____

____

____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health related activities? ❏ 5 ❏ 4 ❏ 3 ❏ 2 ❏ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? ____

____

____

FMG Health Questionnaire

FOOD DIARY - DAY 3

Name: ____ Date: ______________________________

Daily Exercise (Type of Activity / Time of Day / Duration): ___________________________________

____

Daily Bowel Movements: ____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

You should use this form to submit to your Physician's office to release records to FMG.
Name of Facility or Person: ____
Address: ____
Telephone Number: ( ) ______ – ___________ Fax Number: ( ) ______ – ______________

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to FMG all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:
Alcohol or Drug Abuse ❏ Yes ❏ No
Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: ❏ Yes ❏ No Genetic Testing: ❏ Yes ❏ No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose. This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.
I hereby release FMG, its employees, agents, managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.
I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

____

____

Please Print Your Name DOB

____

____

Patient Signature Date

RESEARCH CONSENT AGREEMENT

Patient's Name: ____

Patient's Address: ____

____

THE STUDIES

You are being asked to provide your consent for FMG to use information from your medical records in research studies the goal of which is to improve the practices of the functional medicine approach. **No personal identifying information will be used in the study**.

Principal Investigator of these research studies is Krishna Doniparthi, M.D.

If you consent to the use of your medical records in these research studies, your personal information will be kept confidential to the extent permitted by law and will not be released without your written permission except as described in this paragraph. In all study forms, you will be identified only by a randomly selected patient number. **Your name will not be reported in any publication**; only the data obtained as a result of the use of your medical records in these studies will be made public.

Your decision as to whether or not to consent to the use of your medical records is completely voluntary (of your free will). If you decide not to consent to the use of your medical records it will not affect the care you receive.

If you decide to consent to the use of your medical records in connection with these studies, you may withdraw consent at any time without affecting the care you receive. You should contact the Principal Investigator and let him know about your decision if you decide to withdraw consent.

AGREEMENT TO PARTICIPATE

I have read the description of the research studies and general conditions. Anything I did not understand was explained to me by:_________________________, any questions I had were answered by:__________________________. I hereby give my consent to FMG to use my medical records as described herein in connection with the research studies described herein. I will receive a copy of this Consent Form.

____

Signature of Patient/Legal Representative

____

Print Name of Person

____

Date

____

Name of Person Obtaining ConsentSelling Nutritional and Herbal Supplements

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, ____, have read and understand the above statement on ___________________ (date), witnessed by
____________________________, __________________ (date).