

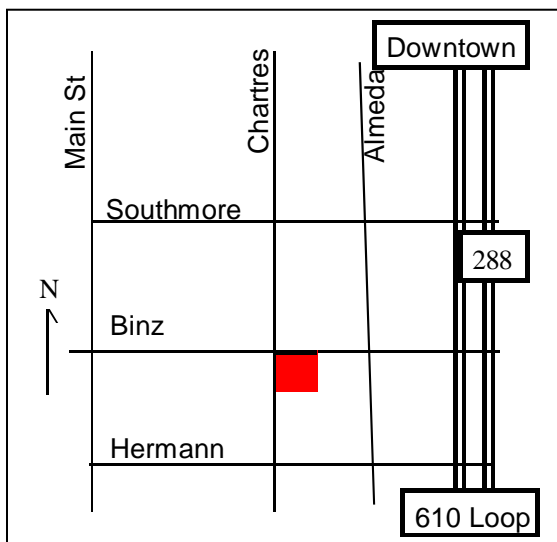
CENTER FOR WELLNESS AND HEALING

2002 Binz Street * Houston, Texas 77004 * 713 520 9611 * 713 520 9618 Fax * CWH2004@aol.com

PAMELA B. ATKINS, MD

Instructions and Directions

1. PLEASE COMPLETE THESE DOCUMENTS AND FAX THEM TO OUR OFFICE BEFORE YOUR APPOINTMENT.
 2. BRING ANY RECENT LABWORK AND/OR DIAGNOSTIC STUDIES AND ALL THE MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING IN FOR YOUR APPOINTMENT.
 3. ALSO, PLEASE BRING THESE ORIGINAL FORMS AT THE TIME OF YOUR APPOINTMENT.
- Our offices hours are by appointment 10:30 am to 4:30 pm Monday thru Friday.
 - We are located in the Museum District, just north of the Medical Center (see map).



Exit 288 at Southmore/Binz/Calumet
Go west on Binz 2 blocks to Chartres
Tan brick building on left.

OR
From Medical Center:
North on Main St. to Binz, turn right;
Go 8 blocks to Chartres.

**2002 Binz near Alameda
Museum District**

INTEGRATIVE SERVICES:

- Bioidentical Hormonal & Thyroid Balancing
- Detoxification/Cleansing Program
- Immune System Support for Optimal Health
- Natural approach to treatment of Diabetes
- Nutritional Wellness Programs
- Digital Infrared Thermal Imaging
- Preventive Healthcare Programs
- Well Woman/Man Examinations

CENTER FOR WELLNESS AND HEALING

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PATIENT INFORMATION

PLEASE COMPLETE AS FULLY AS POSSIBLE

DATE: _____

PATIENT NAME _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

SOC SEC _____ DATE OF BIRTH _____ MARITAL STATUS _____

PHONE [Day] _____ [Evening] _____ [Mobile] _____

EMAIL ADDRESS _____

OCCUPATION _____

GUARDIAN / NEAREST RELATIVE/ CONTACT: _____

CONTACT NUMBER: _____ 2nd NUMBER: _____

RESPONSIBLE PARTY _____
(NAME) (ADDRESS)

(CITY) (STATE/ZIP)

Are you under a doctor's care? _____ Reason _____

PHYSICIAN'S NAME and ADDRESS _____

I hereby give my permission to be examined and treated by Dr. Pamela Atkins.

DATE _____ PATIENT SIGNATURE _____

**Referred by: _____

HISTORY QUESTIONNAIRE

DATE: _____ **NAME** _____ **DOB:** _____
Height: _____ *Weight:* _____

WHAT IS THE PRIMARY REASON FOR YOUR VISIT? _____

(CIRCLE ALL THAT APPLY)

ROS: Constitutional Symptoms: fever weight loss fatigue headaches weight gain sweating
 Eyes: blurred vision double vision blindness cataracts pain
 Ears,Nose,Mouth,Throat: ringing ears hearing loss congestion cavities soreness infection
 Cardiovascular: chest pain palpitations leg edema varicose veins leg pain on ambulation
 Gastrointestinal: heartburn stomach ulcers constipation liver problems hemorrhoids tumors
 Genitouninary: urination: painful frequent during nighttime kidney stones recurrent infections
 Musculoskeletal: joint pain stiff joints cramps muscle pain amputation fractures
 Integumentary rashes ulcers lesions dryness recent mole changes
 Neurological: paralysis numbness tingling burning feet radiating pain headache
 Psychiatric: depression anxiety agitation memory difficulty sleeping
 Endocrine: night sweats cold hands/feet hot flashes hyperactive fatigue dry skin
 Hematologic/Lymphatic: bruises pain tenderness masses swelling anemia
 Allergic/Immunologic: allergies sinusitis frequent colds influenza hepatitis HIV
 Respiratory: asthma emphysema pneumonia short of breath chronic cough/bronchitis

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS....

DIABETES	STROKE	HEART DX	HYPERTENSION	ARTHRITIS	GOUT
CANCER	SEIZURES	ASTHMA	POOR CIRCULATION	BLEEDING DISORDER	ANEMIA
GLAUCOMA	RENAL DX	HEPATITIS B/C	TUBERCULOSIS	OSTEOPOROSIS	VARICOSE VEINS
TUMORS	PACEMAKER	STD's	HIV		

WHAT OPERATIONS OR INJURIES HAVE YOU HAD IN THE PAST?

1) _____ 2) _____
 3) _____ 4) _____
 5) _____ 6) _____

MEDICATIONS?

1) _____ 2) _____ 3) _____
 4) _____ 5) _____ 6) _____
 7) _____ 8) _____ 9) _____

ARE YOU ALLERGIC TO: PENICILLIN NOVACAINE IODINE SULFA CODIENE CORTISONE ASPIRIN
FOODS: _____

FAMILY HISTORY:

	LIVING?	HEALTH CONDITIONS	DECEASED?	CAUSE OF DEATH
MOTHER	_____	_____	_____	_____
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
FATHER	_____	_____	_____	_____
SIBLINGS	_____	_____	_____	_____
SIBLINGS	_____	_____	_____	_____

SOCIAL HISTORY:

TOBACCO:	Packs/day _____	How many years? _____	Usage:
ALCOHOL USE:	Yes _____ No _____	How much? _____ drinks/day	Past _____ Present _____
SUBSTANCE ABUSE:	Yes _____ No _____	How Long? _____	Past _____ Present _____

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FEMALE HORMONAL SYMPTOMS

Please indicate the symptoms you are experiencing as:

0 (none), 1 (mild), 2 (moderate), 3 (severe)

For example, if you are moderately stressed you would indicate this by darkening the "2" next to 'Stress' : ① ② ③ Stress

- | | |
|-----------------------------|------------------------------------|
| ① ② ③ Hot Flashes | ① ② ③ Night Sweats |
| ① ② ③ Foggy Thinking | ① ② ③ Memory Lapse |
| ① ② ③ Heart Palpitations | ① ② ③ Bone Loss |
| ① ② ③ Aches and Pains | ① ② ③ Fibromyalgia |
| ① ② ③ Allergies | ① ② ③ Sensitivity to Chemicals |
| ① ② ③ Sugar Craving | ① ② ③ Elevated Triglycerides |
| ① ② ③ Loss of Scalp Hair | ① ② ③ Increase Facial or Body hair |
| ① ② ③ Tender Breasts | ① ② ③ Bleeding Changes |
| ① ② ③ Anxious | ① ② ③ Water Retention |
| ① ② ③ Weight Gain-Hips | ① ② ③ Decreased Stamina |
| ① ② ③ High Cholesterol | ① ② ③ Swelling or Puffy Eyes, Face |
| ① ② ③ Hair Dry or Brittle | ① ② ③ Nails Breaking or Brittle |
| ① ② ③ Constipation | ① ② ③ Rapid Heart Beat |
| ① ② ③ Hoarseness | ① ② ③ Increased Urinary Urge |
| ① ② ③ Low Blood Pressure | ① ② ③ Numbness-Feet and Hands |
| ① ② ③ Vaginal Dryness | ① ② ③ Incontinence |
| ① ② ③ Tearful | ① ② ③ Depressed |
| ① ② ③ Sleep Disturbed | ① ② ③ Headaches |
| ① ② ③ Morning Fatigue | ① ② ③ Evening Fatigue |
| ① ② ③ Stress | ① ② ③ Cold Body temperature |
| ① ② ③ Weight Gain-Waist | ① ② ③ Decreased Libido |
| ① ② ③ Acne | ① ② ③ Mood Swings |
| ① ② ③ Nervous | ① ② ③ Irritable |
| ① ② ③ Fibrocystic Breasts | ① ② ③ Uterine Fibroids |
| ① ② ③ Decreased Muscle Size | ① ② ③ Rapid Aging |
| ① ② ③ Slow Pulse Rate | ① ② ③ Decreased Sweating |
| ① ② ③ Thinning Skin | ① ② ③ Infertility Problems |
| ① ② ③ Hearing Loss | ① ② ③ Goiter |
| ① ② ③ Low Blood Sugar | ① ② ③ High Blood Pressure |
| ① ② ③ Other | |

Name _____ Date _____

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MALE HORMONAL SYMPTOMS

Please indicate the symptoms you are experiencing as:

0 (none), 1 (mild), 2 (moderate), 3 (severe)

For example, if you are moderately stressed you would indicate this by darkening the "2" next to 'Stress' : 0 1 2 3 Stress

- | | |
|--------------------------------------|---------------------------------|
| 0 1 2 3 Burned Out Feeling | 0 1 2 3 Apathy |
| 0 1 2 3 Decreased Mental Sharpness | 0 1 2 3 Depressed |
| 0 1 2 3 Nervous | 0 1 2 3 Anxious |
| 0 1 2 3 Decreased Stamina | 0 1 2 3 Decreased Muscle Size |
| 0 1 2 3 Decreased Flexibility | 0 1 2 3 Neck/Back Pain |
| 0 1 2 3 Elevated Triglycerides | 0 1 2 3 Sugar Craving |
| 0 1 2 3 Headaches | 0 1 2 3 Ringing in Ears |
| 0 1 2 3 Sensitivity to Chemicals | 0 1 2 3 Decreased Erections |
| 0 1 2 3 Decreased Urine Flow | 0 1 2 3 Increased Urinary Urge |
| 0 1 2 3 Bone Loss | 0 1 2 3 Stress |
| 0 1 2 3 Swelling or Puffy Eyes, Face | 0 1 2 3 Slow Pulse Rate |
| 0 1 2 3 Nails Breaking or Brittle | 0 1 2 3 Thinning Skin |
| 0 1 2 3 Rapid Heart Beat | 0 1 2 3 Hearing Loss |
| 0 1 2 3 Low Blood Sugar | 0 1 2 3 High Blood Pressure |
| 0 1 2 3 Oily Skin or Hair | 0 1 2 3 Acne |
| 0 1 2 3 Difficulty Sleeping | 0 1 2 3 Increased Forgetfulness |
| 0 1 2 3 Mental Fatigue | 0 1 2 3 Irritable |
| 0 1 2 3 Morning Fatigue | 0 1 2 3 Evening Fatigue |
| 0 1 2 3 Sore Muscles | 0 1 2 3 Increased Joint Pain |
| 0 1 2 3 Weight Gain (Breasts/Hips) | 0 1 2 3 Weight Gain-Waist |
| 0 1 2 3 Heart Palpitations | 0 1 2 3 Dizzy Spells |
| 0 1 2 3 Cold Body Temperature | 0 1 2 3 Allergies |
| 0 1 2 3 Decreased Libido | 0 1 2 3 Prostate Problems |
| 0 1 2 3 Hot Flashes | 0 1 2 3 Night Sweats |
| 0 1 2 3 Rapid Aging | 0 1 2 3 High Cholesterol |
| 0 1 2 3 Decreased Sweating | 0 1 2 3 Hair Dry or Brittle |
| 0 1 2 3 Infertility Problems | 0 1 2 3 Constipation |
| 0 1 2 3 Goiter | 0 1 2 3 Hoarseness |
| 0 1 2 3 Low Blood Pressure | 0 1 2 3 Numbness-Feet or Hands |
| 0 1 2 3 Aggressive Behavior | 0 1 2 3 Other |

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LOW THYROID SCREENING

- Do you have fatigue? Yes___ NO___
- Do you have elevated cholesterol? Yes___ NO___
- Do you have difficulty losing weight? Yes___ NO___
- Do you have cold hands and feet? Yes___ NO___
- Are you sensitive to the cold? Yes___ NO___
- Do you have difficulty thinking? Yes___ NO___
- Do you find it hard to concentrate? Yes___ NO___
- Do you experience brain fog? Yes___ NO___
- Do you have poor short term memory? Yes___ NO___
- Are your moods depressed? Yes___ NO___
- Are you experiencing hair loss? Yes___ NO___
- Do you have less than one bowel movement a day? Yes___ NO___
- Do you have dry skin? Yes___ NO___
- Does your skin itch in the winter? Yes___ NO___
- Do you have fluid retention? Yes___ NO___
- Do you have recurrent headaches? Yes___ NO___
- Do you sleep restlessly? Yes___ NO___
- Are you tired when you awaken? Yes___ NO___
- Do you have afternoon fatigue? Yes___ NO___
- Do you experience tingling/numbness in your hands or feet? Yes___ NO___
- Do you have decreased sweating? Yes___ NO___
- Have you had problems with infertility or miscarriages? Yes___ NO___
- Do you have recurrent infections? Yes___ NO___
- Do your muscles ache? Yes___ NO___
- Do you have joint pain? Yes___ NO___
- Do you have thinning of your eyebrows or eyelashes? Yes___ NO___
- Is your tongue enlarges with teeth indentations? Yes___ NO___
- Is your skin pasty, puffy or pale? Yes___ NO___
- Do you have decreased body hair? Yes___ NO___
- Is your voice hoarse? Yes___ NO___
- Do you have a slow pulse? Yes___ NO___
- Do you have low blood pressure? Yes___ NO___
- Does your body temperature run below the normal 98.6°? Yes___ NO___
- Do you have sleep apnea? Yes___ NO___

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YEAST OVERGROWTH SCREENING

- Do you have fatigue? Yes___ NO___
- Do you feel lethargic? Yes___ NO___
- Do you have recurrent yeast infections? Yes___ NO___
- Have you taken antibiotics multiple times during your life? Yes___ NO___
- Do you have abdominal bloating, cramping or gas? Yes___ NO___
- Do you have indigestion or heartburn? Yes___ NO___
- Do you have abnormal bodily reactions to wine, beer or alcoholic beverages, such as flushing, headache, sinus congestion or itchy skin? Yes___ NO___
-
- Do you crave sugar or bread products? Yes___ NO___
- Do you have difficulty concentrating? Yes___ NO___
- Do you have depressed moods? Yes___ NO___
- Do you develop skin rashes or hives? Yes___ NO___
- Do you have athlete's foot? Yes___ NO___
- Do you have jock itch? Yes___ NO___
- Do you have rectal itching? Yes___ NO___
- Do you have fungal infections under the toenails or fingernails? Yes___ NO___
- Do you have allergy symptoms? Yes___ NO___
- Do you have recurrent respiratory infections? Yes___ NO___
- Do you have joint pain? Yes___ NO___
- Do you have muscle pain? Yes___ NO___

Name _____ Date _____