T. Mark Bedillion, MD

Health Consulting

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Detailed Patient Information Intake Form

Please **print this document**, using a pen, fill out the part of the form that applies to you. Fax or email this form before your consultation. We will review this information prior to your consult, and use this information to expedite the consulting process.

New Patient Information

Must be completed and faxed or emailed 1 day prior to consultation

Fax: 512-532-6699 Email: Mark@PrepareMD.com

Name:				Date:
Address:			City:	
State:	Zip:	Home Ph:	Work Ph:	
Cell:	Email:			Preferred: Email ___ Ph___
Age:	DOB:	Status: M D S W	# Children:	Sex: M ___ F ___
Occupation:		Employer:		Yrs Employed:
Spouse:		Emergency Contact Name / Ph:		
Person Responsible for Payment:			Referred by:	
Your Primary Doctor:		City/State:		Last Visit:
Other Specialists: (1)		(2)	(3)	
Health Insurance(s) / No(s):				
What is your #1 medical issue or reason for this consult?				
Other major health issues: (1)			(2)	
What are your major overall health goals? (1)				
(2)		(3)		

Payment: I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand that many of the consulting fees will not be covered by insurance.

Consulting vs. Primary Care: I understand that Dr. Bedillion is not my primary care physician and that I need to remain under the care of a physician for screenings for cancer and other diseases. Dr. Bedillion is acting as my health coach and is focused on lifestyle changes and non-medical interventions like nutrition, sleep, exercise, and supplements that may help to prevent medical problems.

Patient's Signature: ________________________________ **Date:** __________

T. Mark Bedillion, MD

Begin Patient Questionnaire

Past Medical History

List the top 5 symptoms or problems you would like to improve	Do you have an interest in any specific treatments?
1)	
2)	
3)	
4)	
5)	
6) Example: I lack energy	Any testing that might help? Supplements? Hormones?

Allergies and Sensitivities Medications, Chemical, Environmental	What reaction do you have?

Smoking History

Do you smoke? Yes____ No_____ How much? _______ Packs per day? __________
If you quit? When? _____How many yrs did you smoke? ____
How many packs a day on average? _______

List your HEALTH PROBLEMS in order of importance	Date of Onset	Describe - Treatments - Outcome
1)		
2)		
3)		
4)		
5)		

6)		
7)		
8)		
9)		
10)		
Example: Weight Gain	2 yrs ago	2 diet programs, lost some, but gained wt back

Hospitalizations: Which Hospital	**Date**	**Reason for Hospitalization**

Past Diagnostic Studies	**Date**	**Reason for Test – Results of Test**
Heart: EKG		
Heart: Stress Test – Treadmill – or Echo		Abnormal stress test?
Heart: Catheterization or Angiogram of Coronaries		Any blockage? Abnormal pumping?
Heart: Coronary Calcium CT		Heart Saver Coronary Calcium Score?
Colonoscopy or EGD		
Breast: Mammogram, Ultrasound, MRI		
Prostate: Biopsy, Ultrasound		
Chest X-ray or other chest studies		
Brain: CT, MRI, EEG		
Spine: MRI, Plain X-rays		
Arteries: Arteriogram, Carotid Arteries		Any blockages?
Other: Describe		

Past Surgeries	**Date**	**Reason for Surgery – Outcome - Complications**

Past Surgeries:		

Frequency and severity scoring of the symptoms listed – 10 worst / most frequent	Frequency 1-10	Severity 1-10	After marking 1-10 in the boxes, add details in this column
Muscle Pain (1=mild, 10=severe)			
Stiffness			
Unrefreshing Sleep			
Insomnia			
Daytime Fatigue			
Headaches			
Gastrointestinal Disturbances			
Numbness			
Impaired Concentration			
Memory Loss			
Post-exertional Fatigue			
My Energy Level			
My Sense of Well Being			

Major Life Stresses Illness, Surgery, Financial, Family, Etc	Date	Comments - Recovery
1)		
2)		
3)		
4)		
5)		

Do you have a history of … see below? (place checkmarks)	Yes	No	Do you have a history of … see below? (place checkmarks)	Yes	No
Strokes	☐	☐	Cancer: type ___________________	☐	☐
Autoimmune Disease: SLE RA MS	☐	☐	Migraine Headaches	☐	☐
Deep Vein Thrombosis (clots in veins)	☐	☐	Abnormal Heart Beat: type _______	☐	☐
Pulmonary Emboli (PE) (clots into the lungs)	☐	☐	Asthma	☐	☐
Abnormal bleeding	☐	☐	GERD – meds? ________________	☐	☐
Abnormal formation of blood clots	☐	☐	IBS – Irritable Bowel Syndrome	☐	☐

Angina (chest pains/tightness from heart)	☐	☐	IBD – Crohn's, or Ulcerative Colitis	☐	☐
Heart Attack	☐	☐	Acne	☐	☐
High Cholesterol – specify _______________	☐	☐	Psoriasis	☐	☐
Do you have a history of … see below? (place checkmarks)	**Yes**	**No**	**Do you have a history of … see below? (place checkmarks)**	**Yes**	**No**
Arthritis: what kind _____________________	☐	☐	Eczema	☐	☐
History of Substance Abuse	☐	☐	Gout	☐	☐
Tobacco	☐	☐	Thyroid: High or Low? ___________	☐	☐
Alcohol: drinks per day ______ week ______	☐	☐	Prostate Enlargement	☐	☐
Hepatitis	☐	☐	High Blood Pressure	☐	☐
Pancreatitis	☐	☐	Diabetes	☐	☐
Weight Gain in the Abdomen – Spare Tire	☐	☐	Neurological Disease	☐	☐
Diabetes: Juvenile Onset ____ Adult ______	☐	☐	Low Back Pain	☐	☐
Toxic Chemical Exposures	☐	☐	Sciatica	☐	☐
Write in any diseases not listed!	☐	☐	Recent weight loss	☐	☐
Write in:	☐	☐	Recent weight gain	☐	☐
Write in:	☐	☐	Write in:	☐	☐
Write in:	☐	☐	Write in:	☐	☐
Write in:	☐	☐	Write in:	☐	☐
Write in:	☐	☐	Write in:	☐	☐

Prescription Medication History

Medication you take now **OR** took in the past	Dose	Currently Taking? Or Discontinued? When?	Did the medication help?	Single main reason it was discontinued?
			Helped ___________ Didn't help _______ Don't know ______	Side effects________ Didn't work_________ Too expensive______
			Helped ___________ Didn't help _______ Don't know ______	Side effects________ Didn't work_________ Too expensive______
			Helped ___________ Didn't help _______ Don't know ______	Side effects________ Didn't work_________ Too expensive______
			Helped ___________ Didn't help _______ Don't know ______	Side effects________ Didn't work_________ Too expensive______
			Helped ___________ Didn't help _______ Don't know ______	Side effects________ Didn't work_________ Too expensive______

Medication you take now **OR** took in the past	Dose	Currently Taking? Or Discontinued? When?	Did the medication help?	Single main reason it was discontinued?
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______
			Helped ___________ Didn't help ________ Don't know _______	Side effects_________ Didn't work__________ Too expensive_______

Have you taken these medications in the past?

Medication	Did it help?	Reason stopped	When? Why stopped?
Any blood thinner	Yes____No____	Side effects____ Didn't work ____	
Plavix	Yes____No____	Side effects____ Didn't work ____	
Coumadin	Yes____No____	Side effects____ Didn't work ____	
Any hormones	Yes____No____	Side effects____ Didn't work ____	
Testosterone	Yes____No____	Side effects____ Didn't work ____	
Thyroid Meds	Yes____No____	Side effects____ Didn't work ____	
DHEA	Yes____No____	Side effects____ Didn't work ____	
Cortisol	Yes____No____	Side effects____ Didn't work ____	

Have you taken these medications in the past?

Medication	Did it help?	Reason stopped	When? Why stopped?
Estrogen	Yes____No____	Side effects____ Didn't work ____	
Progesterone	Yes____No____	Side effects____ Didn't work ____	
Growth Hormone	Yes____No____	Side effects____ Didn't work ____	
Any anti-anxiety meds	Yes____No____	Side effects____ Didn't work ____	
Xanax	Yes____No____	Side effects____ Didn't work ____	
Valium	Yes____No____	Side effects____ Didn't work ____	
Buspar	Yes____No____	Side effects____ Didn't work ____	
Any sleep meds	Yes____No____	Side effects____ Didn't work ____	
Ambien	Yes____No____	Side effects____ Didn't work ____	
Any antidepressants	Yes____No____	Side effects____ Didn't work ____	
Zoloft	Yes____No____	Side effects____ Didn't work ____	
Trazadone	Yes____No____	Side effects____ Didn't work ____	
Paxil	Yes____No____	Side effects____ Didn't work ____	
Wellbutrin	Yes____No____	Side effects____ Didn't work ____	
Seroquel	Yes____No____	Side effects____ Didn't work ____	
Lamictal	Yes____No____	Side effects____ Didn't work ____	
Neurontin	Yes____No____	Side effects____ Didn't work ____	
Zantac	Yes____No____	Side effects____ Didn't work ____	
Nexium	Yes____No____	Side effects____ Didn't work ____	
Protonix	Yes____No____	Side effects____ Didn't work ____	
Osteoporosis meds	Yes____No____	Side effects____ Didn't work ____	
Statins	Yes____No____	Side effects____ Didn't work ____	
Lipitor	Yes____No____	Side effects____ Didn't work ____	
Birth Control Pills	Yes____No____	Side effects____ Didn't work ____	
Beta-blockers	Yes____No____	Side effects____ Didn't work ____	
Diuretics	Yes____No____	Side effects____ Didn't work ____	
Pain medications	Yes____No____	Side effects____ Didn't work ____	
	Yes____No____	Side effects____ Didn't work ____	

Nutritional supplements you are taking	Reason – Is it helpful?

Are you sensitive to any nutritional supplements?	Reaction you had

Have you had the normal vaccines?	Have you or anyone in your family had a reaction to a vaccine? Is their autism or ADHD in your family?
Yes_____ No______ Explain:	Reactions to vaccines? Yes_____ No_____
	Autism? Yes____ No____ ADHD? Yes____ No____

What things or treatments have you found helpful in the past?

What things or treatments have you found of no benefit in the past?

What things or treatments have made you worse in the past?

Symptoms: frequency of symptoms?	No Symptom Never	Few or Sometimes	Moderate or Regularly	Much of Often	Always or Extreme
Poor tolerance to stress	○	○	○	○	○
Anxiety with stress	○	○	○	○	○
Low blood pressure	○	○	○	○	○
Tired during the day	○	○	○	○	○
Fatigue or mood improved w sweets?	○	○	○	○	○
Salt cravings	○	○	○	○	○
Inflammatory disease-arthritis, asthma	○	○	○	○	○
Brown spots or increased pigmentation	○	○	○	○	○
Eczema, psoriasis, or dandruff	○	○	○	○	○
Weak or tired when standing up	○	○	○	○	○
Weight gain? (____lbs over ____yrs)	○	○	○	○	○
Low body temperature (under 98 degr)	○	○	○	○	○
High cholesterol	○	○	○	○	○
Cold intolerance – always cold	○	○	○	○	○
Dry skin	○	○	○	○	○
Thin hair	○	○	○	○	○

Symptoms: frequency of symptoms?	No Symptom Never	Few or Sometimes	Moderate or Regularly	Much of Often	Always or Extreme
Heavy periods – Females only	○	○	○	○	○
Cold hands and feet	○	○	○	○	○
Generalized fatigue	○	○	○	○	○
Morning fatigue	○	○	○	○	○
Poor motivation for required tasks	○	○	○	○	○
Depression	○	○	○	○	○
Headaches	○	○	○	○	○

Water retention					
Constant swollen eyelids					
Swollen calves / feet					
Difficulty losing weight despite dieting					
Constipation					
Slow growing or brittle nails					
Symptoms: frequency of symptoms?	**No Symptom Never**	**Few or Sometimes**	**Moderate or Regularly**	**Much of Often**	**Always or Extreme**
Diminished sweating					
Hoarse voice					
Coarse skin (rough skin)					
(GH) Thinning hair					
Thinning skin					
Longitudinal lines on nails					
Premature wrinkling on face					
Loose or sagging skin					
Thinning lips					
Overweight					
Decreased muscle strength or tone					
Flabby muscles (triceps of arm or other					
Wrinkled hands					
Weight gain around belly					
Symptoms: frequency of symptoms?	**No Symptom Never**	**Few or Sometimes**	**Moderate or Regularly**	**Much of Often**	**Always or Extreme**
Difficult to stay up late					
Difficult to recover after staying up late					
Need for a lot of sleep (over 10 hours)					
Not assertive					
Anxiety					
Mood swings					
Low self esteem					
Loss of feeling of well-being					

Excess fat	◯	◯	◯	◯	◯
Loss of muscle or strength	◯	◯	◯	◯	◯
Decreased memory	◯	◯	◯	◯	◯
Bleeding gums	◯	◯	◯	◯	◯
Easy bruising	◯	◯	◯	◯	◯
Poor libido (sex drive)	◯	◯	◯	◯	◯
Swollen prostate	◯	◯	◯	◯	◯
Wake up at night to urinate frequently	◯	◯	◯	◯	◯
Decreased erections	◯	◯	◯	◯	◯
Trouble falling asleep	◯	◯	◯	◯	◯
Symptoms: frequency of symptoms?	**No Symptom Never**	**Few or Sometimes**	**Moderate or Regularly**	**Much of Often**	**Always or Extreme**
Awaken in the middle of the night	◯	◯	◯	◯	◯
Leg jumping and jerking or crawling	◯	◯	◯	◯	◯
Excessive nightly worrying	◯	◯	◯	◯	◯
Waking up tired (not enough sleep)	◯	◯	◯	◯	◯
Snoring	◯	◯	◯	◯	◯
Disordered breathing while asleep	◯	◯	◯	◯	◯
Toenail or fingernail fungal changes	◯	◯	◯	◯	◯
Diarrhea	◯	◯	◯	◯	◯
Gas	◯	◯	◯	◯	◯
Bloating	◯	◯	◯	◯	◯
Dry eyes	◯	◯	◯	◯	◯
Gas	◯	◯	◯	◯	◯
Frequent infections requiring antibiotics	◯	◯	◯	◯	◯
Burning on urination	◯	◯	◯	◯	◯
Chronic allergies	◯	◯	◯	◯	◯
Chronic bad breath	◯	◯	◯	◯	◯
Irritation or inflammation of gums	◯	◯	◯	◯	◯
Panic attacks	◯	◯	◯	◯	◯
Symptoms: Frequency of symptoms?	**No Symptom Never**	**Few or Sometimes**	**Moderate or Regularly**	**Much of Often**	**Always or Extreme**

Family History

Have any of your blood relatives had the following diseases?	Which Relatives	Comments - Details
Breast cancer		
Prostate cancer		
Ovarian or uterine cancer		
Lung cancer		Smoking history?
Other cancers: list		
Heart attacks		Smoking history?
Congestive Heart Failure		
Any Autoimmune Disease - Lupus		
Alzheimer's Disease		
Depression		
Other mental issues		
Diabetes		
Obesity		
Asthma		
Chemical sensitivities		
High Blood Pressure		
Parkinson's Disease		
Others: list:		