Environmental Health Center of Martha's Vineyard **Phone Consult Form and Waiver**

Fill in all spaces that apply. Please print. **Date of completion** _____ **Age** _____ **Date of Birth:**_____

Name: _____ **Gender:** _____ **E-mail:** _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

Whom may we thank for referring you? _____ **Occupation:**_____

May we leave a message on your answering machine? Y/N On your e-mail? Y/N

Financially Responsible Party: if same circle yes_____ **Relationship:** _____

Regarding phone discussions with Dr. Lisa Nagy:

I am considering coming to the office for an appointment and would like to discuss some general issues with her and get her take on whether she is appropriate for my medical condition. I will pay her for her time on my credit card, which is not tax deductible. The charge is $375.00 for 45-minute discussion. If the conversation runs longer, it is billed at the rate of $500.00 per hour. By signing, I acknowledge that I am not a patient yet and that Dr. Nagy will not suggest supplements or medications to take or to not take. She will give general advice on what to read, videos to watch, and doctors I could see in my region to help me.

Dr. Nagy might also suggest tests to ask my doctor to perform or consultants to involve in my care. She is not able to prescribe medication or order lab work for me, as we do not have a doctor/patient relationship yet. I am interested in guidance about avoiding toxicity in air, food, and water and also how to assess my home for problems with mold. I understand that the medical board does not permit medical treatment over the phone unless I have been examined and will agree to come in person before considering Dr. Nagy my doctor in any way.

Furthermore, in an emergency I will go to the ER or get a hold of my primary doctor and not await a return call from Dr. Nagy.

Phone appointments are nonrefundable, and not billable to insurance.

I understand and agree to these parameters and charges.

Signature: _____

Printed Name: _____ **Date:** _____

BRIEF PATIENT HISTORY

Date:

Name (last, first):

DOB:

Age:

Current Problems, Worst Symptoms First:
Mold Exposed, circle one: **YES /** No

Medications (Do not say "see other page"):

Past Illnesses / Surgeries (age or year):

Toxic Home, Hobby, Pesticides, Solvents, or Work Exposures:

Travel History (country, month, year):

Musty Basements /Mold Exposure (year, location, severity):

Allergies (medications/supplements):

Anaphylaxis, circle one: **YES /** No
Allergies (environmental e.g. pollens cats):

Social History (cigs, alcohol, drugs, etc.):

Married / Divorced Children's Ages_____
Is anyone else ill in home?_____

Lyme History:
Tick Bite
Treatment:
Testing Results:

Significant Family History of Illness: Age/Age of Death:
Mother:
Father:
Siblings:
Spouse:
Children:

GYN History: Pregnancies:__ Births:__ Abortions:__ Miscarriages:_
Bad Menstrual Cramps: Yes / No / Severe
Last Period:_____ Birth Control Type:_____
Hormones used in the past? Yes / No

Circle Yes or No		
Yes	Are you very chemically sensitive? Mild / Moderate / Severe	No
Yes	Are you **EMF** sensitive? Does a cell phone heat up in your hand or give you a headache?	No
Yes	Do fluorescent lights, Wi-Fi, refrigerators, or motors irritate you? (Circle all that apply)	No
Yes	Do you have to cut tags out of clothing?	No
Yes	Do you dislike standing for a long time?	No
Yes	Do you pretzel your legs when sitting?	No
Yes	Is this worse when sitting at a computer?	No
Yes	Do you have a fast heartbeat when standing or lying in bed?	No
Yes	Do you cross your arms or lean on the wall when standing?	No
Yes	Do you get dizzy upon standing after tying shoes?	No
Yes	Do you have exercise/heat intolerance? (Circle all that apply)	No
Yes	Do you crave/or like salt, chips or sugar? (Circle all that apply)	No
Yes	Are you tired in the morning / 4 p.m.? (Circle all that apply)	No
Yes	Do you have motion sickness reading in car, on a boat, or while taxiing in a plane	No
Yes	Do you have trouble walking up a ladder or looking down from heights?	No
Yes	Do your arms get tired when washing hair / folding laundry?	No
Yes	Is it difficult to mop the floor / vacuum?	No
Yes	Are you ill or tired in the mall or home depot?	No
Yes	Can you smell chemicals inside these stores?	No
Yes	Do you avoid or smell the detergent aisle in the grocery store?	No
Yes	Is bra too tight and you prefer not to wear one/cannot wear one?	No
Yes	Do you have arm/skin discomfort if you roll up your tight sleeves?	No
Yes	Do you urinate more that once at night or many times a day	No
Yes	Are you very flexible? Can you bend thumb toward forearm?	No

SYMPTOM SEVERITY RECORD Patient's Name:_____.

Enter today's date in the first available column at top of grid. List all symptoms you've had in the past few days or last appointment in the column on the left. Please rate them on a scale of 0 to 10, with 10 being the worst.

Symptom List	**Date Completed** (Write in on a slant.)																		
	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Nervous/Anxious																			
Irritable																			
Depressed																			
Suicidal																			
Tearful																			
Fatigue																			
Muscle Weakness																			
Joint Pains																			
Headaches																			
Memory Problems																			
Foggy Thinking																			
Chilly/Cold hands/feet																			
Bowel problems																			
Chemical Sensitivity																			
Electrical Sensitivity																			
Allergy Symptoms																			
Sexual Function prob.																			
Libido problems																			
Hrs of Sleep/night																			
Pain																			
Insomnia																			
Fast heart beat																			
Tired after eating																			
Irrit. by clothing tags																			
Reading problems																			
Sick in stores/malls																			
Sensitive to mold																			
Heat intolerance																			
Exercise intolerance																			
Combative behavior																			