PROBLEM LIST & DRUGS/SUPPLEMENT LIST

Please take a moment to detail your specific health concerns for Dr. Sharif so that he may be able to better serve you.

PATIENT'S NAME: _____

TODAY'S DATE: _____

1) Health concern #1: _____

How long has this problem been bothering you? _____

How often does it bother you? _____

How severe (1-10) is the intensity of this problem? _____

Better with anything? Worse with anything? _____

Other relevant info? _____

2) Health concern #2: _____

How long has this problem been bothering you? _____

How often does it bother you? _____

How severe (1-10) is the intensity of this problem? _____

Better with anything? Worse with anything? _____

Other relevant info? _____

3) Health concern #3: _____

How long has this problem been bothering you? _____

How often does it bother you? _____

How severe (1-10) is the intensity of this problem? _____

Better with anything? Worse with anything? _____

Other relevant info? _____

NOTE: If you have **OTHER** health concerns you'd like to discuss with Dr. Sharif, list them all on a second page. Typed-up would be much preferred to hand-written.

PLEASE PROVIDE A LIST OF ALL OF YOUR DRUGS & SUPPLEMENTS:

DRUG NAME *HOW OFTEN?*

SUPPLEMENT NAME *HOW MANY AND HOW OFTEN?*

NOTE: Please list your own supplements plus the ones Dr. Sharif has prescribed for you, ideally two separate list. This list is going to change visit after visit. Therefore, please fill this form out every time.