Comprehensive Evaluation Form – Routine Maintenance ReEvaluation (DCEF-RMR)
(Part I: Historical and Symptom Information)

Note: If you have previously filled out this form, address and mark only those items that have changed since your previous assessment. Circle NC for no change by all sections where there are no interval changes in your history or circle None or N/A for sections not applicable.

Office use: Reevaluation – day/week/month/yr of tx:____7, 14, 21, 30, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15, 18, 21

Demographic information:
Name: ____________________________
Date: ______________

Reason(s) appointment was made:
___Physical/preventative exam – initial/yearly
___Diabetes/diabetes prevention
___Weight loss/body composition treatment
___Cardiovascular disease (heart disease, stroke)
___Metabolic syndrome
___Other

___Migraine Headaches
___Chronic fatigue
___High blood pressure
___High cholesterol
___Hormone treatment
___Hormone treatment only
___Depression/anxiety
___Asthma/allergies

Physician Use Only/HPI:
____________________________________________________________________________________________________________
________________________________________________________________________________________________
______________________________________________________________________________________________________

Medication History/Substance Abuse History: Always complete the section below or provide a current list of your medicines.

Current prescription/over the counter medications as prescribed (use two lines for a treatment where necessary):

<table>
<thead>
<tr>
<th>Drug or Medication</th>
<th>Dosage/Frequency/date started</th>
<th>Drug or Medication</th>
<th>Dosage/Frequency/date started</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g. Imitrex tablets)</td>
<td>100 mg. twice a day/1996</td>
<td>(e.g. Prozac)</td>
<td>20 mg. a day/2002</td>
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</tbody>
</table>

Are you taking medications as prescribed? ___yes ___no
If no, comment:_________________________________________________________________________________________

Substance Use: None NC

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Last Use</th>
<th>Frequency (daily, wkly, etc.)</th>
<th>Amount Used (?, wt, volume, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
</tr>
<tr>
<td>Cocaine</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
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<tr>
<td>IV Drug</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
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<tr>
<td>Marijuana</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
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<tr>
<td>Narcotics (i.e. Vicodin, Heroin)</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
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<tr>
<td>Stimulants</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
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<tr>
<td>Tobacco</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
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<tr>
<td>Other</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
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<tr>
<td>Drug Allergies:</td>
<td>________</td>
<td>____________________________</td>
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<tr>
<td>Environmental Allergies:</td>
<td>________</td>
<td>____________________________</td>
<td>_______________________________</td>
</tr>
</tbody>
</table>

*Always fill out this section completely if you are being followed/treated for substance abuse.*
**Diet/Exercise History:**
Circle the choice that best describes your current diet.

- Regular
- See food
- Kosher
- Low fat
- Low cal
- High fat/high carb
- Vegetarian
- Low carb
- Other: ____________

Compliance with diet:  
- Good
- Fair
- Poor

Type of exercise:  
- None
- Running
- Jogging
- Walking
- Biking
- Swimming
- Aerobics
- Weight lifting

___ x/week

**Social History:**  
- No Change
- New stressors/changes:__________________________

**Symptom Review** (Circle any symptoms for which you are being treated and any new symptoms.)

Place an N in the blank beside all new symptoms. For all treated symptoms rate your current level of improvement by placing one of the following in the adjacent blank:

- R (resolved)
- I (improved)
- W (worse)
- NC (no change)

**General:**
- Weight loss [ ]
- Weight gain [ ]
- Fever [ ]
- Fatigue [ ]
- Excessive energy [ ]
- Low motivation [ ]
- Appetite change [ ]
- Difficulty concentrating [ ]
- Memory loss [ ]
- Poor response to diet/exercise for weight loss [ ]

**Skin:**
- Rashes [ ]
- Itching [ ]
- Color changes [ ]
- Changes in hair texture [ ]
- Loss of scalp/body hair [ ]

**Eyes:**
- Vision changes [ ]
- Blurred vision [ ]
- Glasses/contacts [ ]

**EENT:**
- Sinus pain [ ]
- Earache [ ]
- Sore throat [ ]
- Headaches [ ]
- Swollen glands [ ]
- Nasal stuffiness [ ]
- Runny nose [ ]
- Itching eyes/ears [ ]
- Rescue inhaler use per week [ ]

**Respiratory:**
- Cough [ ]
- Wheezing [ ]
- Asthma [ ]
- Bronchitis [ ]
- Pneumonia [ ]
- Snoring [ ]
- Runny nose [ ]
- Itching eyes/ears [ ]
- Rescue inhaler use per week [ ]

**Cardiac:**
- Chest pain [ ]
- Palpitations [ ]
- Rheumatic fever [ ]
- Edema [ ]
- Murmur [ ]

**GI:**
- Heartburn [ ]
- Vomiting [ ]
- Indigestion [ ]
- Diarrhea [ ]
- Black stools [ ]
- Rectal bleeding [ ]
- Constipation [ ]
- Hemorrhoids [ ]
- Gas [ ]
- Food intolerance [ ]
- Lack of bowel control [ ]
- Regurgitating sour fluid [ ]
- Problems swallowing [ ]

**Urinary:**
- Increased need to urinate [ ]
- Sudden urge to urinate [ ]
- Pain on urination [ ]
- Uncontrolled loss of urine [ ]
- Slowing of the urinary stream [ ]
- Increased nighttime urination [ ]
- Pain in the testicles [ ]

**GYN:**
- Irregular periods [ ]
- PMS [ ]
- Pelvic Pain [ ]
- Menstrual cramps [ ]
- Vaginal dryness [ ]
- Vaginal discharge [ ]
- Hot flashes [ ]
- Breast tenderness [ ]
- Pain with intercourse [ ]

**Sexual function:**
- Problems with erections [ ]
- Premature ejaculation [ ]
- Loss of sex drive [ ]
- Difficulty achieving orgasm [ ]
- Troubling sexual thoughts/desires [ ]
- Pain with intercourse [ ]

**Musculoskeletal:**
- Muscle/joint pains [ ]
- Arthritis [ ]
- Gout [ ]
- Back pain [ ]
- Joints affected: wrists [ ]
- elbows [ ]
- shoulders [ ]
- knees [ ]
- hips [ ]
- spine [ ]
- feet [ ]
- Loss of muscle mass, tone, or strength [ ]

**Neurologic:**
- Fainting [ ]
- Blackouts [ ]
- Seizures [ ]
- Numbness [ ]
- Weakness [ ]
- Headaches [ ]
- Restless legs/jerking, kicking in sleep [ ]

**Hematologic:**
- Anemia [ ]
- Unexplained easy bleeding/bruising [ ]

**CNS:**
- Depression [ ]
- Anxiety [ ]
- Panic attacks [ ]
- Mood swings [ ]
- Manic episodes [ ]
- Low motivation [ ]
- Memory loss [ ]
- Difficulty concentrating [ ]
- Worsening job performance [ ]
- Binge eating [ ]
- Anorexia [ ]
- Hallucinations [ ]
- Racing thoughts [ ]
- Crying spells [ ]
- Difficulty sitting still [ ]

**Sleep:**
- Sleep problems [ ]
- Type – Getting to sleep [ ]
- Staying asleep [ ]
- Restless legs/arms [ ]
- Snoring [ ]
- Pauses in breathing [ ]
- Going days on little or no sleep [ ]
- Jerking in sleep [ ]

Elaborate on any of the above if needed:

Do you believe you are experiencing any treatment side effects? If so, list:__________________________

__________________________________________________________________________________________________