HEALTH AND FITNESS INFORMATION

General Information

Date:_____

Date of first Appointment:_____

Name:_____

Address:_____

_____

_____

Phone: (h)_____(w)_____ (c)_____

Email Address: _____

Date of Birth:_____

Weight:_____ Height:_____

Occupation:_____

Medical Doctor:_____

PRIMARY GOALS FOR CONSULTATION

1)_____

2)_____

3)_____

4)_____

5)_____

How were you referred to us?_____

Method of Payment: **Cash** **Check** **VISA, MasterCard, or Discover**

Frank J. Trombetta, D.Sc.
711-B South Grove Street, Hendersonville, NC 28792
828-696-1915

All information will be held in the strictest confidence

HEALTH & FITNESS HISTORY

List major childhood illnesses you have had: _____

_____

List all surgeries and hospitalizations: _____

_____

List major accidents and injuries: _____

_____

List all areas of pain (experienced within past four months: _____

_____

_____

List all diagnosed or suspected Illnesses, Diseases, and Health Problems: _____

_____

_____

List all known allergies: _____

List method of birth control (if any) : _____

List all Prescription Medications taken within past 12 months: _____

_____

_____

List all non-prescription medications taken within past 12 months (including aspirin, hormones, laxatives, antacids, diet aids, etc): _____

_____

_____

List all Vitamins, Minerals, Enzymes, and Herbs now taking or recently taken: _____

_____

_____

Briefly describe your current dietary program and eating habits: _____

_____

_____

Briefly describe and exercise program you are now following regularly: _____

_____

_____

Briefly identify ant stress factors of which you are aware:

Family: _____ **School /Work:** _____

Social: _____ **Environmental:** _____

Briefly note Diseases and Surgeries experienced by members of your immediate family:

Spouse: _____ Age: _____

Father: _____ Age: _____

Mother: _____ Age: _____

Sisters: _____ Age: _____

Brothers: _____ Age: _____

Children: _____ Age: _____

When was your most recent visit to a physician? _____

List any tests done: _____

Note any religious or personal beliefs relevant to health, illness, or treatment methods, if any:

_____

SYMPTOMS SURVEY

If you have had any of these health and fitness problems or symptoms within the past year, please check box:

- ❒ **Coughed up or vomited blood**
- ❒ **Black or bloody stool**
- ❒ **Brown, black, or bloody urine**
- ❒ **Yellowing in the whites of your eyes**
- ❒ **Nagging cough, hoarseness, or sore throat that did not heal within 10 days**
- ❒ **Discovered a breast lump or unexplained lump or cyst anywhere in the body**
- ❒ **Unexplained thickening anywhere in the body**
- ❒ **Experienced a marked and unexplained weight loss, sudden shortness of breath, or any dramatic change in your normal body functioning**
- ❒ **Have had a crushing pain in the center of the chest that may have been accompanied by pain radiating down the left arm, severe nausea, clammy skin, difficulty in breathing, or an irregular heartbeat**
- ❒ **Have had a cut, sore, or lesion that hasn't healed or an obvious enlargement or change in warts or moles**
- ❒ **Have experienced unexplained rapid or irregular heartbeats**
- ❒ **Have experienced unexplained dizziness, blurred or distorted vision, fainting spells, or blackouts**
- ❒ **Have experienced prolonged fatigue or exhaustion**
- ❒ **Have received a blow to the head that caused unconsciousness**
- ❒ **Have had abdominal pain that lasts for 12 hours or more and is very intense for several hours**
- ❒ **Have had an obvious blockage of the intestinal tract**
- ❒ **Have swallowed any dangerous/poisonous chemicals, drugs, or toxic substances**
- ❒ **Have been in an accident and suffered lacerations, serious abrasions, broken bones, possible whiplash or other injuries (known or suspected)**
- ❒ **Have had great tightness in the chest or great difficulty swallowing**
- ❒ **Have had an oral temperature over 102 degrees for more than 48 hours**
- ❒ **Have a hernia**

HEALTH APPRAISAL QUESTIONNAIRE

Frank J. Trombetta, D.Sc.

NAME _____ DATE: _____

PART I

Circle any of the following medications you are taking:

Antacids	Antibiotic/Antifungal	Antidepressants	Antidiabetic/Insulin
Aspirin/Tylenol	Chemotherapy	Cortisone/AntiInflamatories	Heart Medications
High Blood Pressure	Hormones	Laxatives	Lithium
Oral Contraceptives	Radiation	Relaxants/Sleeping Pills	Recreational Drugs:
Thyroid	Ulcer Medications	Other: _____	_____

Circle if you eat, drink, or use:

Alcohol	Candy	Carbonated Beverages(soda)	Cigarettes
Coffee	Distilled Water	Fast Food- regularly	Fried Foods
Luncheon Meats	Margarine	Vitamins/Minerals	Refined Sugars
Saccharine (Sweet 'n Low)	Chewing Tobacco		

Circle if you:

Diet often	Do *not* exercise regularly	Salt food without tasting
Are under excessive stress	Are exposed to chemicals at work	Are exposed to cigarette smoke

INSTRUCTIONS: Circle the number which describes the intensity of your symptoms. If you don't know the answer, leave it blank.
0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe

PART II

1. Swollen Eyes (bulging)	0 1 2 3	9. Depressed, apathetic	0 1 2 3
2. Strong smelling urine	0 1 2 3	10. Low sex drive	0 1 2 3
3. Thick skin and fingernails	0 1 2 3	11. Premenstrual tension	0 1 2 3
4. Dry skin	0 1 2 3	12. Muscle pain or stiffness	0 1 2 3
5. Sensitive to the cold	0 1 2 3	13. Thinning/loss :outside portion of eyebrow	0 1 2 3
6. Cold hands and feet	0 1 2 3	14. Gain weight easily	0 1 2 3
7. Chronic fatigue	0 1 2 3	15 Axillary (armpit) temperature below 97.6	NO YES
8. Trouble waking up in A.M.	0 1 2 3	16. Infertility	NO YES

PART III

SECTION A:

1.	Pain in fingers	0 1 2 3	
2.	Bones sore/painful	0 1 2 3	
3.	Eat meat	0 1 2 3	
4.	Cavities	0 1 2 3	
5.	Arthritis	0 1 2 3	
6.	Drink carbonated beverages (#/ week)	0 1-3 4-7 7+	
7.	Use antacid (#/ week)	0 1-3 4-7 7+	
8.	Bone loss	NO YES	
9.	Gum disease	NO YES	
10.	Calcium deposits	NO YES	
11.	Dentures	NO YES	
12.	Bone deformity	NO YES	
13.	Told you have osteoporosis/osteopenia	NO YES	
14.	Recent bone fracture	NO YES	
15.	Had a hysterectomy or post-menopausal	NO YES	

SECTION B:

1.	Muscle spasms	0 1 2 3	
2.	Tightness in shoulder muscles	0 1 2 3	
3.	Muscle cramps	0 1 2 3	
4.	Pain in arms, hands	0 1 2 3	
5.	Leg cramps at night	0 1 2 3	
6.	Stiff all over	0 1 2 3	
7.	Stiff in morning	0 1 2 3	
8.	Unable to sit up straight	0 1 2 3	
9.	Pain in neck and/or shoulders	0 1 2 3	
9.	Pain in neck and/or shoulders	0 1 2 3	

SECTION C:

1.	Over flexible joints (double jointed)	0 1 2 3	
2.	Back pain	0 1 2 3	
3.	Swollen knees/elbows	0 1 2 3	
4.	Athletic injury	0 1 2 3	
5.	Bursitis	0 1 2 3	
6.	Tendonitis	0 1 2 3	
7.	Joint pain	0 1 2 3	
8.	Slipped disc	NO YES	
9.	Herniated disc	NO YES	
10.	Loss in height	NO YES	
11.	Injure easily	NO YES	

PART IV

SECTION A:

1.	Feel tired in the afternoon	0	1	2	3
2.	Itchy eyes	0	1	2	3
3.	Red or inflamed eyes	0	1	2	3
4.	Low blood pressure	0	1	2	3
5.	Sensitive to exhaust fumes, smoke, smog, petrochemicals	0	1	2	3
6.	Cannot tolerate much exercise	0	1	2	3
7.	Depression or rapid mood swings	0	1	2	3
8.	Dark circles under the eyes	0	1	2	3
9.	Dizziness upon standing	0	1	2	3
10.	Lack of mental alertness	0	1	2	3
11.	Catch colds when weather changes	0	1	2	3
13.	Eyes sensitive to bright light	0	1	2	3
14.	Feel weak and shaky	0	1	2	3

SECTION B:

1.	Running nose	0	1	2	3
2.	Get boils or styes	0	1	2	3
4.	Loss of smell	0	1	2	3
5.	Throat infections	0	1	2	3
6.	Cold sores, fever blisters	0	1	2	3
7.	Loss of taste	0	1	2	3
8.	Poor wound healing	0	1	2	3
9.	Hair falls out	0	1	2	3
10.	Swollen lymph glands	0	1	2	3
11.	Ear infections	0	1	2	3
12.	Slow to recover from cold or flu	0	1	2	3
13.	Catch colds or flu easily	0	1	2	3
14.	Bumpy skin on back of arms	0	1	2	3

SECTION C :

1.	Itching of nose or eyes	0	1	2	3
2.	Itching of roof of mouth or throat	0	1	2	3
3.	Entire body aches, painful to touch	0	1	2	3
4.	Swollen joints	0	1	2	3
5.	Mucus in throat	0	1	2	3
6.	Post nasal drip	0	1	2	3
7.	Discharge from eyes	0	1	2	3
8.	Watery eyes	0	1	2	3
9.	Puffiness or dark circles under eyes	0	1	2	3
10.	Ear discharge or ears stuffed up	0	1	2	3
11.	Nasal congestion	0	1	2	3
12.	Running nose	0	1	2	3
13.	Breathe through mouth	0	1	2	3
14.	Swollen tongue	0	1	2	3
15.	Difficulty swallowing	0	1	2	3
16.	Hyperactivity	0	1	2	3
17.	Chronic lung congestion	0	1	2	3
18.	Skin rashes	0	1	2	3
19.	Breathe through mouth	0	1	2	3

PART V

SECTION A:

1.	Difficulty breathing at night	0	1	2	3
2.	Chest pain while walking	0	1	2	3
3.	Heaviness in legs	0	1	2	3
4.	Calf muscles cramp while walking	0	1	2	3
5.	Heart pounds easily	0	1	2	3
6.	Feel jittery	0	1	2	3
7.	Heart misses beats or has extra beats	0	1	2	3
8.	Swelling of feet and ankles	0	1	2	3
9.	Rapid beating heart	0	1	2	3
10.	Heartburn after eating	0	1	2	3
11.	Pain in left arm	0	1	2	3
12.	Exhaust with minor exertion	0	1	2	3
13.	Dr. has said you have heart trouble	NO			YES

SECTION B:

1.	Cold hands and feet	0	1	2	3
2.	Slurred speech	0	1	2	3
3.	Headaches	0	1	2	3
4.	Numbness in extremities	0	1	2	3
5.	Poor concentration	0	1	2	3
6.	Ringing in ears	0	1	2	3
7.	Tingling and/or burning in hands or feet	NO			YES
8.	Spider veins on nose and/or face	NO			YES

SECTION C:

1.	Pain upon waking in back of head & neck	0	1	2	3
2.	Dizziness	0	1	2	3
3.	Vertigo	0	1	2	3
4.	Blushing with no apparent cause	0	1	2	3
5.	Do you have high blood pressure?	NO			YES

PART VI

SECTION A:

1.	Dizziness when standing suddenly	0	1	2	3
2.	Loss of vision when standing suddenly	0	1	2	3
3.	Crave sweets	0	1	2	3
4.	Headaches relieved by eating sweets or consuming alcohol	0	1	2	3
5.	Feel shaky or jittery	0	1	2	3
6.	Irritable if a meal is missed	0	1	2	3
7.	Feel tired or weak if a meal is missed	0	1	2	3
8.	Wake up during night craving sweets	0	1	2	3
9.	Heart palpitations after eating sweets	0	1	2	3
10.	Need to drink coffee to get started	0	1	2	3
11.	Impatient, moody, nervous	0	1	2	3
12.	Feel tired 1 to 3 hours after eating	0	1	2	3
13.	Poor memory	0	1	2	3
14.	Feel faint	0	1	2	3
15.	Poor concentration	0	1	2	3
16.	Forgetful	0	1	2	3
17.	Calmer after eating	0	1	2	3

SECTION B:

1.	Night sweats	0	1	2	3
2.	Increased thirst	0	1	2	3
3.	Lowered resistance to infection	0	1	2	3
4.	Fatigue	0	1	2	3
5.	Boils and leg sores	0	1	2	3
6.	Lesions and cuts take long time to heal	0	1	2	3
7.	Overweight	0	1	2	3
8.	Sugar in urine	0	1	2	3
9.	Family history of Diabetes	NO			YES
10.	Crave sweets, but eating sweets does relieve craving	NO			YES

PART VII

1.	Chest pain	0	1	2	3	5.	Coughing up blood	0	1	2	3
2.	Chronic cough	0	1	2	3	6.	Coughing up phlegm	0	1	2	3
3.	Difficulty breathing	0	1	2	3	7.	Pain around ribs	0	1	2	3
4.	Shortness of breath	0	1	2	3	8.	Rattling mucus when you breathe	0	1	2	3

PART VIII

1.	Frequent urination	0	1	2	3	9.	Rose colored (bloody) urine	0	1	2	3
2.	Frequent bladder infections	0	1	2	3	10.	Strong smelling urine	0	1	2	3
3.	Rarely need to urinate	0	1	2	3	11.	Cloudy urine	0	1	2	3
4.	Urination when you cough or sneeze	0	1	2	3	12.	Back or leg pains associated with dripping after urination	0	1	2	3
5.	Pain/burning when passing urine	0	1	2	3						
6.	Difficulty passing urine	0	1	2	3	13.	Frequent vaginal infections	0	1	2	3
7.	Dripping after urination	0	1	2	3	14.	Back pain in the kidney area	0	1	2	3
8.	Can't hold urine	0	1	2	3	15.	General water retention	0	1	2	3
						16.	History of kidney or bladder infections	NO			YES

PART IX: For Females Only

SECTION A: Circle if you experience any of these symptoms within approximately 2 weeks prior to menstruation.

1.	Monthly weight gain	0	1	2	3	9.	Anger	0	1	2	3
2.	Depression	0	1	2	3	10.	Tender breasts	0	1	2	3
3.	Moodiness/Irritabilty	0	1	2	3	11.	Low backache	0	1	2	3
4.	Bloating and swelling	0	1	2	3	12.	Suicidal feelings	0	1	2	3
5.	Nausea and/or vomiting	0	1	2	3	13.	Asthma attacks	NO			YES
6.	Anxiety	0	1	2	3	14.	Missed periods	NO			YES
7.	Leg cramps and tenderness	0	1	2	3	15.	Over 15 years old and have not begun menstruation	NO			YES
8.	Easily distracted	0	1	2	3						
						16.	Unable to get pregnant	NO			YES

SECTION B: Check if you experience any of these symptoms during menstruation

1.	Low abdominal pain	0	1	2	3	9.	Nausea and/or vomiting	0	1	2	3
2.	Dull ache radiating to low back/ legs	0	1	2	3	10.	Have to lie down on day 1 or 2 of period	0	1	2	3
3.	Increased urinary frequency	0	1	2	3	11.	Craving for sweets	0	1	2	3
4.	Pelvic soreness	0	1	2	3	12.	Insomnia	0	1	2	3
5.	Diarrhea	0	1	2	3	13.	Light scanty blood flow	0	1	2	3
6.	Headaches	0	1	2	3	14.	Pain and cramps without blood flow	0	1	2	3
7.	Abdominal bloating	0	1	2	3	15.	Heavy menstrual bleeding	0	1	2	3
8.	Menstrual pain	0	1	2	3	16.	Pain during period gets progressively worse	0	1	2	3

SECTION C:

1.	Vaginal bumps or sores	0	1	2	3	9.	Ovarian cysts	NO			YES
2.	Sore pubic area	0	1	2	3	10.	Uterine cysts	NO			YES
3.	Pain in ovaries	0	1	2	3	11.	Breast lumps	NO			YES
4.	Breasts sore to touch	0	1	2	3	12.	Mother used D.E.S. (hormones) while pregnant	NO			YES
5.	Breasts painful	0	1	2	3						
6.	Water retention	0	1	2	3	13.	Recent pap smear positive	NO			YES
7.	Swollen feeling	0	1	2	3	14.	Family history of breast cancer	NO			YES
8.	Premenstrual breast pain or discomfort	0	1	2	3	15.	Birth control pills	NO			YES

PART X: For Males Only

SECTION A:

1.	Difficulty urinating	0	1	2	3	6.	Wake up to urinate during night	0	1	2	3
2.	A sense of bladder fullness	0	1	2	3	7.	Dripping after urination	0	1	2	3
3.	Increased straining with less urine passed	0	1	2	3	8.	Pain or fatigue in legs or back	0	1	2	3
4.	Rose colored (bloody) urine	0	1	2	3	9.	Lack of sex drive	0	1	2	3
5.	Pain or buring while urinating	0	1	2	3	10.	Ejaculation causes pain	0	1	2	3

SECTION B:

1.	Difficulty attaining and/or maintaining an erection	0	1	2	3	4.	Pain/coldness in the genital area	0	1	2	3
						5.	Infertile	NO			YES
2.	Low sexual drive	0	1	2	3	6.	Varicose veins on scrotum	NO			YES
3.	Premature ejaculation	0	1	2	3	7.	Low sperm count	NO			YES

The Bowel- Liver

Patient Assessment Booklet

Please complete the enclosed questionnaire based upon your health profile over the last 30 days. Upon completion, return booklet for analysis.

Name _____

Date _____

THESE QUESTIONS ARE BASED UPON A HIGHLY ACCURATE SYMPTOM PROFILE DESIGNED BY CORNELL MEDICAL UNIVERSITY. RESEARCH HAS DEMONSTRATED THAT WITH PROPER ANALYSIS OF YOUR RESPONSES YOUR PRACTITIONER WILL BE ABLE TO PROVIDE YOU WITH A NUTRITIONAL PROTOCOL SPECIFICALLY TAILORED TO SUPPORT YOUR INDIVIDUAL NEEDS.

HEALTH APPRAISAL - BRIEF

NAME_____ DATE_____

CIRCLE the number which best describes the ***frequency*** of your symptoms. If you do not know the answer the the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Point** box. The score for YES is the number inside the parenthesis ( ).

(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily or several times a day

PART I

Section A

1. Indigestion	0	1	2	3
2. Belching, burping	0	1	2	3
3. Gas immediately following a meal	0	1	2	3
4. Sense of fullness during meals	0	1	2	3
5. Poor appetite, picky eater	0	1	2	3
6. Difficult bowel movements	0	1	2	3
7. Difficulty swallowing	0	1	2	3
8. History of anemia, unresponsive to iron	N			Y (10)
9. Vegetarian (no eggs, dairy)	N			Y (5)
10. Spoon shaped nails	N			Y (3)
11. Unintentional weight loss	N			Y (3)
12. Partial loss of taste or smell	N			Y (3)

Total Points_____

Section B

1. Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
2. Pain, tenderness, soreness on left side under rib cage	0	1	2	3
3. Bloated	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Abdominal cramps, aches	0	1	2	3
6. Nausea and/or vomiting	0	1	2	3
7. Specific foods/beverages aggravate indigestion	0	1	2	3
8. Roughage and fiber causes constipation	0	1	2	3
9. Three or more large bowel movements daily	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Undigested food in stool	0	1	2	3
12. Mucus in stool	0	1	2	3
13. Dry, flaky skin, dry brittle hair	N			Y (3)
14. Difficulty gaining weight	N			Y (3)

Total Points_____

Section C

1. Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2. Feeling hungry an hour or two after eating	0	1	2	3
3. Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
4. Heartburn, especially when lying down, bending forward	0	1	2	3
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6. Difficulty or pain when swallowing	0	1	2	3
7. Chest pain or infections, difficulty breathing	0	1	2	3
8. For relief from carbonated beverages, cream/milk/food	0	1	2	3
9. Constipation	0	1	2	3
10. Black, tarry stool	0	1	2	3

Total Points_____

Section D

1. Lower abdominal pain, cramping and/or spasms	0	1	2	3
2. Lower abdominal pain relief by passing stool or gas	0	1	2	3
3. Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
4. Diarrhea (loose watery stool)	0	1	2	3
5. More than three bowel movements daily	0	1	2	3
6. Excessive gas and bloating	0	1	2	3
7. Painful, difficult, straining during bowel movements	0	1	2	3
8. Hard, dry or small stool	0	1	2	3
9. Extremely narrow stools	0	1	2	3
10. Alternating diarrhea/constipation	0	1	2	3
11. Mucus, pus in stool	0	1	2	3
12. Feeling that bowels do not empty completely	0	1	2	3
13. Bright red blood following bowel movement	0	1	2	3
14. Anal itching	0	1	2	3

Total Points_____

PART II

Section A

1. Moderate to severe pain under right side of rib cage	0	1	2	3
2. Abdominal pain worsens with deep breathing	0	1	2	3
3. Regurgitate bitter fluid	0	1	2	3
4. Bloated, full feeling	0	1	2	3
5. Belching, heartburn, gas	0	1	2	3
6. Fatty foods cause indigestion	0	1	2	3
7. Nausea or vomiting	0	1	2	3
8. Feel restless, agitated	0	1	2	3
9. Unexplained itchy skin worse at night	0	1	2	3
10. Stool color alternates from clay colored to normal brown	0	1	2	3
11. Feeling of poor health	0	1	2	3
12. Fatigue, weakness, exhaustion	0	1	2	3
13. Unable to concentrate, irritable, confused	0	1	2	3
14. Swollen feet and/or legs	0	1	2	3
15. Easy bruising	0	1	2	3
16. Feeling of extreme dryness	0	1	2	3
17. Reddened skin, especially palms	0	1	2	3
18. Dark urine, diminished flow	0	1	2	3
19. Dry, flaky skin, hair	N			Y (3)
20. Yellowish cast to skin, eyes	N			Y (3)

Total Points_____

Toxicity Self Test

Initial Testing Scale

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

POINT SCALE:

0 = Never or almost never have symptom
1 = Occasionally have it, the effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

Digestive Tract	_____Nausea or vomiting _____Diarrhea _____Constipation _____Bloated Feeling _____Belching or passing gas _____Heartburn	Total _____
Ears	_____Itchy Eyes _____Ear aches, ear infections _____Drainage from ear _____Ringing in ears, hearing loss	Total _____
Emotions	_____Mood Swings _____Anxiety, fear or nervousness _____Anger, irritability or aggressiveness _____Depression	Total _____
Energy & Activity	_____Fatigue, sluggishness _____Apathy, lethargy _____Hyperactivity _____Restlessness	Total _____
Eyes	_____Watery or itchy eyes _____Swollen, reddened or sticky eyelids _____Bags or dark circles under eyes _____Blurred or tunnel vision [does not include near or far sightedness]	Total _____
Head	_____Headaches _____Faintness _____Dizziness _____Insomnia	Total _____
Heart	_____Irregular or skipped heartbeat _____Rapid or pounding heartbeat _____Chest Pain	Total _____
Joints & Muscles	_____Pain or aches in joints _____Arthritis _____Stiffness or limitation of movement _____Pain or aches in muscles _____Feeling of weakness or tiredness	Total _____

Lungs	_____Chest Congestion _____Asthma, bronchitis _____Shortness of breath _____Difficulty Breathing	Total _____
Mind	_____Poor memory _____Confusion, poor comprehension _____Difficulty in making decisions _____Stuttering or stammering _____Slurred speech _____Learning disabilities	Total _____
Mouth / Throat	_____Chronic coughing _____Gagging frequently; need to clear throat _____Sore throat, hoarseness, loss of voice _____Swollen or discolored tongue, gums, lips _____Canker sores	Total _____
Nose	_____Stuffy nose _____Sinus problems _____Hay fever _____Sneezing attacks _____Excessive mucus formation	Total _____
Skin	_____Acne _____Hives, rashes, or dry skin _____Hair loss _____Flushing or hot flashes _____Excessive sweating	Total _____
Weight	_____Binge eating/ drinking _____Craving certain foods _____Excessive weight _____Compulsive eating _____Water retention _____Underweight	Total _____
Other	_____Frequent illness _____Frequent or urgent urination _____Genital itch or discharge	Total _____
Grand Total		_____

Frank J. Trombetta, D.Sc.
711-B South Grove Street
Hendersonville, NC 28792
828-696-1915

Authorization for Release of Medical Information

I hereby authorize Frank Trombetta, D.Sc. to release requested information to Dr. James Johnson in order to process testing through "Genova Diagnostics" lab.

Information to be released:

- ☐ **Basic Medical History**
- ☐ **Symptoms leading to need for testing**

Name _____

Address _____

_____

Phone _____

Signature _____

Date _____

This information has been disclosed from records whose confidentiality may be protected by Federal law. Federal regulations (42CFR, Part 2) prohibit making further disclosure of this information except with the informed written consent of the person to whom it pertains.

Thank you.

Frank J. Trombetta, D.Sc.

711-B South Grove Street
Hendersonville, NC 28792
828-696-1915

Please make copies of this form, then fax the completed form directly to your physician, and have them send the information to our office.

Authorization for Release of Medical Information

I hereby authorize: Dr. _____
Address: _____
_____
Phone _____ Fax _____

to release requested information to Frank Trombetta, D.Sc.

Information to be released:

- ☐ **All Blood Work**
- ☐ **All Urine Studies**
- ☐ **Complete records**
- ☐ **Other** _____

Name _____

Address _____

Phone _____

Signature _____ **Date** _____

Relationship, if other than self _____

This information has been disclosed from records whose confidentiality may be protected by Federal law. Federal regulations (42CFR, Part 2) prohibit making further disclosure of this information except with the informed written consent of the person to whom it pertains.

Thank you.