Jacob Mehran Tsadok, M.D.

Hello:

We acknowledge the commitment you are making to your healing and health.
We look forward to our time together.

Please fill out the following registration forms and questionnaire(s).

We are aware of the sensitivity of several of the questions we ask, and if you would prefer not to answer any particular questions at this time, please leave them blank.

Please bring with you to your first visit:

- -these completed forms and questionnaires
- -relevant medical records such as laboratory, radiologic and other test results that you have (if you have access to a fax: please fax these records beforehand to 310-471-7348, or, call your practitioner's office that has copies of recent or relevant reports [only] and ask them to fax to this number.)
- -all medicines, vitamins and supplements you are now taking (the actual bottles)

The pages in these questionnaires are upside down to work well in medical charts.

Thank you and warm regards,

Jacob Mehran. Tsadok, M.D.
A medical corporation

Mailing: 2990 S. Sepulveda Blvd., Ste 203
Los Angeles, CA 90064
Tele: 310-277-9010 Fax: 310-471-7348

Jacob Mehran Tsadok,M.D.

Welcome. Here is some important information that relates to our participation.

Payment is expected at the time services are rendered, unless prior arrangements have been made.

Dr. Tsadok is happy to consult by telephone when appropriate. There is a charge for most telephone consultations depending on the time involved and the situation.

Because of allergic sensitivity of many patients, please do not wear perfume to appointments.

Please give 24 hour notice if you need to change an appointment: a charge will be made for less than 24-hour notice.

I have read and acknowledge the above information. I also give permission for the release of my medical records to other health care providers of my choice.

_____ _____ _____

Signature: Date (Parent or Guardian)

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Special Requirements for Women in Menopause

Dr. Tsadok will work with you as a consultant regarding hormones as well as with issues related to your overall health. To begin or continue to prescribe hormones, he requires that you:

1] Have (or are willing to establish) a professional relationship with a licensed medical practitioner specializing in female medicine (eg: Gynecologist, Nurse Practitioner, Internist or Family Practitioner) so that yearly routine female examinations are performed and will be kept current.

2] Have an annual breast thermogram &/or mammogram, and transvaginal ultrasound depending on what Dr Tsadok recommends.

3] Have a Bone Density test every 1-3 years, as well as appropriate blood and 24 hour urine hormone testing at the appropriate times or intervals.
[Tests 2 &/or 3 can be arranged by our office.]

4] Have a yearly consultation with Dr Tsadok to evaluate and update your hormonal treatment program

If your overall health is reasonable you can expect to begin a bio-identical hormone program in this first visit. Getting this program as safe and elegant as possible is a process and requires a certain amount of follow-up appointments, a few or several, until you arrive at an optimal program. These follow-up appointments are usually shorter in duration than the initial appointment. If other health issues are influencing your current situation (for example depleted neurotransmitters, liver issues, intestinal issues, and/or excessive stress) addressing these will be factored into your program and will call for more time and participation.

Symptoms and health issues are caused by adversities of nutrition, toxicity, inadequate (or excessive) exercise and undo stress. What you think, feel, and choose in the living of your life matters and will be relevant to your health.. Because they are critical to healing, any important issues will be addressed with the intent of assisting you with this part of your healing, or encouraging you to discover the practitioners and process that can help you..

Please feel free to discuss with Dr Tsadok on the telephone any questions you may have about his approach prior to an initial visit with him. To schedule this pre-consultation, email to: tsadok@msn.com.

Name of your Practitioner of Female Medicine: _____

Signature, acknowledging you agree with the approach outlined on this page _____

Jacob Mehran Tsadok, M.D.

Registration form

Name Today's date:

Address: Street: City: State: Zip:

Home Ph.: Work Ph.: Fax: Mobile Ph:

Other Address: Street: City: State: Zip:

Home Ph.: Work Ph.: Fax: Mobile Ph:

Usual dates you are in Florida: email address:

DOB: Age: Referred by: _____

SSN: Female ☐ Male ☐

Single ☐ Married ☐ Other ☐

Insurance company name: Insurance company address:

Insurance company phone number: Your insurance ID numbers:

Name of insured primary person if different than you: Their SSN: Their ID#:

Your relationship to insured primary person: Their Date of Birth:

Allergies to medications.

Telephone number of your favorite pharmacy if you have one:

Name _____ initials ____
date of birth _____ age _____

Medical Questionnaire

Overview Questions

Describe any symptoms, illness &/or health issues you are having now:

Describe any major symptoms, illness &/or health issues you have had in your past:

Regarding your health, what would you most like to accomplish?

initials ____

List any significant:

	Childhood	Adult
illness		
accident/injury		
hospitalization		
surgery		
immunizations		

List significant illness in your family (examples: diabetes, high blood pressure, Alzheimer's, heart disease, cancer, asthma, allergy, alcoholism etc.)

mother	son
father	daughter
maternal grandmother	paternal grandmother
maternal grandfather	paternal grandfather
other	

List any pharmaceutical drugs you are taking now:

List any pharmaceutical drugs you have taken in past:

Are you allergic to any drugs?

Give a 'rough' estimate of number of days in your life you have taken antibiotics:

Describe any chronic or occasionally recurring pain?

Give a 'rough' estimate of:

Coffee intake:now [cups/day]: in past [cups/day]:

*number of cigarettes/day, now_____in past_____

*Alcohol intake [what & how much]: now_____in past_____

*„recreational" drug/day:now _____ in past_____

* = answer optional

Describe any significant „toxic" exposure you have had:

(examples: pesticide, industrial, electromagnetic, pollution..)

Have you had your Mercury amalgams removed?
Do you have any root canals?How Many?
Do you have any dental implants?How Many?
Do you eat fish/seafood frequently?

Describe current and significant past occupations:

Are you married?Have any children? In a committed relationship?
Using contraception now?what type?
Been pregnant?number of live births..

Briefly describe the quality of your personal relationships
(mate, significant other, children, friends, relationships at work, other)

Describe your general energy level. (are you energetic in the morning?, all day? etc.)

On a scale of 1 to 10, 10 being the best, what number would you give your current energy level

Describe how well you sleep?
Sleep great___? Trouble falling asleep___? Trouble staying asleep?

Describe your general sense of mood and well-being
happy in general ___? depressed ___?ok but occasionally depressed ___?
Have you had any stress in your life? [specify with general comments...if you are willing to]

Describe your digestion & bowel movements: Daily ___? number of times per week___?
formed ___?voluminous ___? soft ___? hard ____? constipated___? diarrhea ___?

Have you traveled outside of the United States ___?

where_____?

did you have a diarrhea illness associated with that travel ____?

Do you exercise regularly? please describe:

Symptom Screening Inventory

initials ____

1] "Score" symptoms to the left of them according to the following code:
P = had it in the past, and do not have it currently
0 = never or almost never have the symptom
1 = occasionally have it, 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
2] subtotal your points at the end of each section and enter on the 'subtotal' line to the right
3] total each individual page on the bottom of that page.
4] enter individual page totals at the end of the screening inventory, and total "grand total"

Head

____ headaches
____ fainting
____ dizziness
____ convulsions
____ hair thinning
____ hair drying
____ hair loss

subtotal ____

Eyes

____ blurred vision
____ eye pain
____ difficulty in vision
____ double vision
____ itchy eyes
____ diminished close-up vision
____ spots in front of eyes
____ do you wear glasses?

subtotal ____

Ears

____ earaches
____ ear infections
____ ringing in ears
____ hearing loss
____ itchy ears
____ change in hearing

subtotal ____

Nose

____ stuffy nose
____ nasal discharge
____ nosebleeds
____ sinus problems
____ sinus infections
____ 'post-nasal drip'

subtotal ____

Allergy

____ pollen allergy
____ dust allergy
____ frequent sneezing
____ hay fever
____ asthma
____ frequent or seasonal sneezing & watery eyes
____ stuffy nose after eating
____ trouble going into shopping malls
____ hypersensitivity to medications

subtotal ____

Mouth & Throat

____ canker sores
____ sore gums
____ bleeding gums
____ tooth pain
____ tooth sensitivity
____ coated tongue
____ breath odor
____ difficulty swallowing
____ sore throat
____ do you floss?

subtotal ____

total of page 1 ____

Sleep

____ difficulty in sleeping____ awaken in night with difficulty
____ falling back asleepdifficulty falling asleep
____ sleep less than 7 hours____ 5 hours or less of sleep at night
____ work night or afternoon shift ____ Heavy snoring or gasping
____ disturbing dreams

subtotal ____

Immune

____ 'cold' sores in the mouth
____ known allergies
____ difficulty healing
____ colds or other infections
____ swollen glands

subtotal ____

Cardiovascular

____ irregular or skipped heartbeat ____
____ rapid or pounding heartbeat ____
____ palpitations____
____ chest pain____
____ irregular heart beat____
____ anemia____
____ varicose veins____
leg cramping on walking
leg cramps at night
high blood pressure
pain in legs when walking
fluid retention [swelling]
dizzy upon standing
bruise easily

subtotal ____

Lungs

____ cough
____ shortness of breath in day
____ shortness of breath in night
____ difficulty breathing
____ history of smoking
____ asthma
____ bronchitis

subtotal ____

Intestine

____ nausea
____ vomiting
____ bloated feeling
____ burning in stomach
____ 'heartburn'
____ pain in abdomen
____ diarrhea
____ constipation
____ excessive belching
____ excessive passing gas
____ 'indigestion'
____ craving sweets
____ hepatitis
____ gallstones
____ nausea on eating:
____ fried foods
____ dairy
____ change in appetite
____ discomfort or pain in right upper abdomen or in back
____ discomfort in lower left abdomen
____ foods you have trouble with
____ fatigue or anxiety relieved by sweets
____ indigestion 1-2 hours after eating
____ fullness long after meals
____ sleepy after meals
____ nails bend or break easily
____ blood in stool
____ black stool
____ anal itch
____ pain on defacation
____ hemorrhoids
____ goosebumps' on back of arms

subtotal ____

total of page 2 ____

initials ____

Urinary tract

____ burning or pain on urination
____ bladder infections
____ kidney infections
____ up at night to urinate
____ blood in urine
____

____ frequency of urination
____ urgency of urination
____ fluid retention [swelling]
____ kidney stones
____ does your urine foam?

subtotal ____

Muscles, Bones & Joints

____ pain or ache in joints
____ pain or ache in muscles
____ stiff joints
____ swollen joints
____ muscle tension
____ muscle cramps

____ numbness or tingling
____ weakness or tiredness of muscles
____ chronic or recurrent back or neck pain
____ osteoporosis
____ difficulty in lifting

subtotal ____

Skin

____ pimples or acne
____ dry skin
____ rashes
____ oily skin

____ hives
____ skin itch
____ sweating

subtotal ____

Weight

____ compulsive or binge eating
____ sweet craving
____ excessive weight
____ underweight
____ craving certain foods

____ weight loss
____ weight gain
____ inability to gain weight

subtotal ___

Energy

____ fatigue in general
____ hyperactivity

____ awaken energetic, fatigue easily
____ awaken sluggish, improve with day

subtotal ___

Liver/Toxicity

____ hypersensitivity to odors____ trouble when smelling perfumes
____ not able to drink coffee after ____ trouble with odors in shopping mall
6pm or will be unable to sleep
____ known toxic exposure
[name type_____]

subtotal ___

total of page 3 ☐

Mind & Emotions

____ poor memory
____ poor concentration
____ difficulty in making decisions
____ mood swings
____ anxiety
____ nervousness
____ depression
____ panic attacks

____ irritability or 'moodiness'
____ fear
____ sadness, grief
____ anger
____ shame or guilt
____ self pity
____ 'mid-life crisis'

subtotal ___

Hormonal

____ mid-life weight gain
____ cold intolerance
____ swelling under eyes
____ eye discomfort in bright light
____ sleep disturbance
____ loss of muscle mass or strength
____ sweet craving
____ fatigue or irritability relieved by eating sweets

____ dizzy on standing up quickly from lying or sitting
____ fatigue easily
____ eyes sensitive to bright light
____ irritable when hungry
____ feel better after exercise
____ feel worse after exercise
____ cold hands & feet
____ uncomfortable in cold
____ uncomfortable in heat

subtotal ___

Dental

____ tooth or gum pain
____ Root Canals
____ Mercury Amalgam Fillings
____ gingivitis
____ dental implants

subtotal ___

total of page 4 ☐

total of page 1 ____
total of page 2 ____
total of page 3 ____

Grand Total of all 4 pages ☐

Female Hormone-related Questionnaire

initials _____

Current Age
Approximate date of last menstrual period
Approximate date of last menstrual period at time when your periods were regular
Age of onset of menstruation (Menarche)
How long after Menarche did your periods get regular?
How many days did your menstrual flow last at that time?
What was cycle length when periods got regular at that time?

(number of days from the first day of menstrual flow of one cycle, to the first day of flow of the next)

Prior to the age of 18 or, your first pregnancy:
did you have "PMS" ___yes __no
did you have difficult periods ___yes __no
? breast tenderness: ___yes __no? headaches: ___yes __no
__irritablility?__uterine cramps? __ heavy flow? __bloating?

Birth control methods: __Diaphragm __Condom __both __IUD [__# of years] __tubal ligation
Were you ever on the Birth Control Pill? ___yes __no__# of years or __# of months
If 'yes', how did you feel on it? ___better___worse
did you gain weight while on it? _____yes _____no
Number of ...___miscarriages ___abortions

Have you ever been pregnant & given birth? __yes __no if yes, number of births ___
Your age at each pregnancy_____ _____ ____ _____
Number of months you breast fed this baby _____ _____ ____ _____
After the first 3 months was pregnancy
a very physically pleasant time for you?_____yes _____no
a worse time for you than non-pregnant? _____yes _____no
did you have diabetes during pregnancy? _____yes _____no
did you have nausea of pregnancy?_____yes _____no for how long?____

Have you had a recurrance or worsening of premenstrual symptoms after the age of 35: __yes __no
___PMS ___breast tenderness
After the age of 35, before menopause,
Is there a time of the month that you feel best?week: __1 __ 2: __ 3: __ 4
Is this the only time of the month you feel good? __yes __no

Breast size when younger or, prior to first pregnancy: Bra size_____ Cup size____
Current breast size: Bra size_____ Cup size____

have you had any of the following:
__ breast cysts__breast biopsy__ breast cancer
have you had breast mammograms? if so, how many _____? any abnormal ____?
have you had breast ultrasounds? if so, how many _____? any abnormal ____?
have you had breast thermograms? if so, how many _____? any abnormal ____?
do you have breast implants (if so, when implanted_____?)
what percentage of time in a 24 hour day do you wear a bra? ____%

Have you had any of the following:

__uterine fibroids__D & C [__ # of]__ovarian cysts__endometriosis
__laparoscopic surgeries__cesarian sections__tubal ligation__endometrial biopsy
__hysterectomy: at what age__? __oopherectomy [removal of ovary(s)] ? __1?__2
__age of last pap smear__? abnormal pap smear [at what age__?]
__bone density tests_____ date of last one __normal __osteopenia __osteoporosis

Hormonal use: __Premarin__Provera __patch
__other hormones [list]_____
has any woman in your family had female cancer? __no __yes
if yes, who and what type? __breast__uterine __ovarian
who? _____ _____ _____

Current Height____feet ____inches
tallest height you ever were____feet ____inches
Weight age 25____lbsWeight now ____lbs
In your life have you had more muscle and hair than others? ____
more muscle than others with little body hair? ____?

Symptoms of estrogen deficiency:
__hot flashes__ warm rushes
__kicking covers off at night __vaginal dryness
__trouble falling asleep__mental fogginess
__headaches & migraines__intestinal bloating
__weight gain__back & joint pain
__temperature swings__night sweats
__racing mind @ night
__depression
__diminished sexuality & sensuality
__heart palpitations

Symptoms of estrogen excess:
__breast tenderness [especially central]
__water retention & swelling
__pelvic cramps
__breast swelling or enlarging
__impatient & snappy though with clear mind
__nausea

Symptoms of progesterone deficiency:
__difficulty sleeping__anxiety & nervousness
__no period__infrequent period
__frequent & heavy periods__spotting before period
__cystic breasts__painful breasts
__water retention
__shorter cycle
__PMS
__endometriosis
__fibroids

Symptoms of testosterone deficiency:
__diminished sex drive
__diminished energy & stamina
__diminished coordination & balance
__diminished armpit, pubic & body hair
__diminished love of your body image
__flabbiness
__diminished sense of security
__indecisiveness
__hair loss
__muscle weakness

Instructions for 3 Day Chart

Choose 3 days (they need not be consecutive) that are very representative of your usual living.
(if 3 days seems like too much effort, choose a most typical single day and record for it)

Basal temperatures [1] Put a non-mercury thermometer [or a mercury thermometer if you already own one] on your bedside stand. Very first thing upon awakening, put it in your armpit and take your temperature), before any movement, for at least three mornings. Women, if you can, include 2nd day of menstruation. [2] Also take temperature @ 4pm.

Energy	Draw energy changes in a "graphic" fashion, from 6 am to midnight. Signify on your graphed line, when you eat a meal ("m") or a snack ("s")
Sleep	Describe: going to sleep: physical (tired, restless, energetic, etc.) emotional (ecstatic, angry, etc.) dreaming:(happy, struggle, don't remember, etc.) awakening:physical (energetic, tired, groggy, etc.) emotional (happy, dissonant, etc.) Record time and length of any nap In the „time" column record time asleep and time awake and the total number of hours (e.g. 11PM-6 AM/7 hours).
Supplements	Under "list", list the supplements or medicines you are now taking. Record the number of each you take each day in the columns.
Exercise	Record the amount of time spent in each type listed.
Bowels	Record the time of day, the amount of stool (small, medium, large), the odor (none, interesting, excessive). the form (watery, loose, soft, hard, etc.), and whether they float, sink or hover a bit beneath the surface. Also estimate the number of times a day you pass gas and the odor (none, strong, etc.). Also note the amount of time of any „major" gas after a meal! "Transit time" is a one time procedure. Steam 2 cups of fresh beets and ingest 12-16 hours prior to your usual bowel movement. Record time of eating and time red color first appears in your bowel movement.
Substances	Record intake, if any, of substances such as coffee, tobacco, alcohol, recreational or pharmaceutical drugs.
Emotional	Record a simple description of any significant emotional experience you had and how you handled it
Breathing	Record a rough idea of how much and what type of breathing you do
Water	How many cups per 24 hours
Food	See page following 3 day chart for food recording chart

initials ____

3 Day Chart

Day and Date			
Basal Temperature			
Energy — High	6am 9 12 3 6 9 12	6 9 12 3 6 9 12	6 9 12 3 6 9 12
Energy — Basic			
Energy — Low			
Sleep — going to sleep: physical, emotional, dreaming; waking: physical, emotional; nap; Time: hours of sleep			
Supplements — list			
Exercise — cardiovascular, stretching, other			
Bowels — time, amount, odor, form, float, gas, #			
*transit time (see instructions)			
Substances			
Emotional experience			
Breathing — deep, rapid			
Water — # of cups/day			

initials ____

3 Day Food Intake Record

Instructions:

Choose 3 days for recording that are typical for the way you usually eat.
Record all food intake
Estimate and record amounts
Record time of intake in column provided

	Time	Day 1	Time	Day 2	Time	Day 3
Breakfast						
Snack						
Lunch						
Snack						
Dinner						
Snack						

What percentage of your meals do you eat at restaurants?
What percentage of your food shopping is at health food grocery stores? _____
What percentage of the food you eat is 'Organic'? _____
List foods that you crave: _____

List any foods that you eat more than 3 times per week