PRACTITIONER CONSULTATION - MEDICAL QUESTIONNAIRE

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PERSONAL INFORMATION
First Name: _____ Last Name: _____
Sex: ☐ M ☐ F
Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Wid. ☐ Other _____
Street: _____ Unit # _____ City: _____ State/Prov: _____ Country: _____ Postal Code: _____
Home phone: _____ Cell phone: _____
5. Email address: _____
6. Date of birth: (day/month/year) _____
7. Family contact (e.g. spouse, parent, sibling) Name: _____ Relationship: _____ Contact number: _____
10. Second language (optional): _____
11. Religion (optional): _____

Revised Dec 25, 2025

RECENT HISTORY

Diagnosis of current health problem: ☐ Unknown

How was it diagnosed? Diagnosis date:

Treatments received:

Medication	☐ Yes	☐ No	☐ Not yet, starting soon	☐ Not sure
Surgery	☐ Yes	☐ No	☐ Not yet, soon	☐ Not sure
Natural Therapy	☐ Yes	☐ No	☐ Not yet, starting soon	☐ Not sure
Experimental Therapy	☐ Yes	☐ No	☐ Not yet, starting soon	☐ Not sure
Radiation Therapy	☐ Yes	☐ No	☐ Not yet, starting soon	☐ Not sure

Other:

DETAILS

Please describe ***briefly*** what happened that led to the diagnosis.

Please describe ***briefly*** the sequence of treatment(s), response(s), recurrent problem(s) etc.

PAST HEALTH Do you have (or have you ever had) any of the following? *(check if yes)*

Condition		√	About when was it diagnosed?
Cardiovascular Disease	High blood pressure	☐	
	Angina	☐	
	Heart attack	☐	
	Heart failure	☐	
	Abnormal heart rhythm	☐	
	Blood clot (DVT)	☐	
	High cholesterol	☐	
	Other: specify	☐	
Lung Disease	Asthma	☐	
	Bronchitis / pneumonia	☐	
	Emphysema	☐	
	Other: specify	☐	
Kidney Disease	Stones	☐	
	Infections	☐	
	Kidney failure	☐	
	Other: specify	☐	
GI Disease	Stomach / duodenal ulcer	☐	
	Diverticulitis	☐	
	Reflux / heartburn	☐	
	Irregular bowels	☐	
Liver Disease	Hepatitis	☐	
	Jaundice (yellow eyes/skin)	☐	
	Other: specify	☐	
Neurological Disease	Stroke	☐	
	Seizures	☐	
	Other: specify	☐	
Endocrine Disease	Diabetes, Type 1	☐	
	Diabetes, Type 2	☐	
	Thyroid disease (specify)	☐	
	Adrenal disease (specify)	☐	
	Testicular / ovarian disease	☐	
	Other: specify	☐	

PAST HEALTH Do you have (or have you ever had) any of the following? *(check if yes)*

Problem		√	When?
Skin Disease	Eczema	☐	
	Hives	☐	
	Other:	☐	
Dental Procedures	Root canal(s)	☐	
	Metal ("Silver") Filling(s)	☐	
	Implant(s)	☐	
	Other: specify	☐	
Traumas	Physical / Injury	☐	
	Psychological	☐	
	Sexual	☐	
	Other: specify	☐	
Toxin exposure	Pesticides/herbicides	☐	
	Chemicals	☐	
	Metals	☐	
	Other: specify	☐	
Psychological Issues	Depression	☐	
	Anxiety	☐	
	Phobia	☐	
	Stress	☐	
	Other:	☐	
Sexual Issues	Erectile problem	☐	
	Menstrual problem	☐	
	Infertility	☐	
	Other:	☐	
Prostate Disease		☐	
Urinary Disease		☐	
Cancer (specify type):		☐	
Painful scars		☐	
Problems related to computer use		☐	

Other Health Problems and Surgeries	Approximate date(s)
Problems after **vaccine** or **medication**?	
Received COVID-19 vaccine(s)? ☐ Yes ☐ No	

SOCIAL HISTORY

Occupation

Have you ever smoked cigarettes? ☐ Yes ☐ No
How long? _____ years
How much? _____ per day
Are you still smoking now? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much?
_____ drinks per day OR _____drinks per week OR ☐ occasionally

Have you ever used recreational drugs? ☐ Yes ☐ No
If yes:
Please list: _____

MEDICATIONS – CONVENTIONAL and NATURAL

Please list all of your **current medications and supplements** (name, dose and how often you take them). If you are not sure of the dose, please just list the name(s).

Name	Dose	How often

ALLERGIES / ADVERSE REACTIONS

Have you ever had an **allergy** or **adverse reaction** to any of the following?

Category	Yes √	No √	Please list
Drugs	☐	☐	
Foods	☐	☐	
Others (pollen, grass, pets, etc.)	☐	☐	

FAMILY HISTORY

Please provide the following information regarding blood relatives

Relation	List major illness (e.g. diabetes, cancer, ulcers, blood clots, heart, lung, liver, kidney disease, immune disease)
Father	
Mother	
Sisters	
Brothers	
Children	☐ Not applicable How many boys? _____ How many girls? _____
Other	

ACTIVITY LEVEL

Please check one:	√
Fully active, able to carry on all activities (same as before cancer diagnosis) without restriction.	☐ 0
Restricted in strenuous activity but walking and able to carry out light work e.g. office work.	☐ 1
Walking and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of the day.	☐ 2
Capable of only limited self-care (washing, changing clothes, going to washroom), confined to bed or chair more than 50% of the day.	☐ 3
Completely disabled. Cannot carry on any self-care (washing, changing clothes, going to washroom). Totally confined to bed or chair.	☐ 4

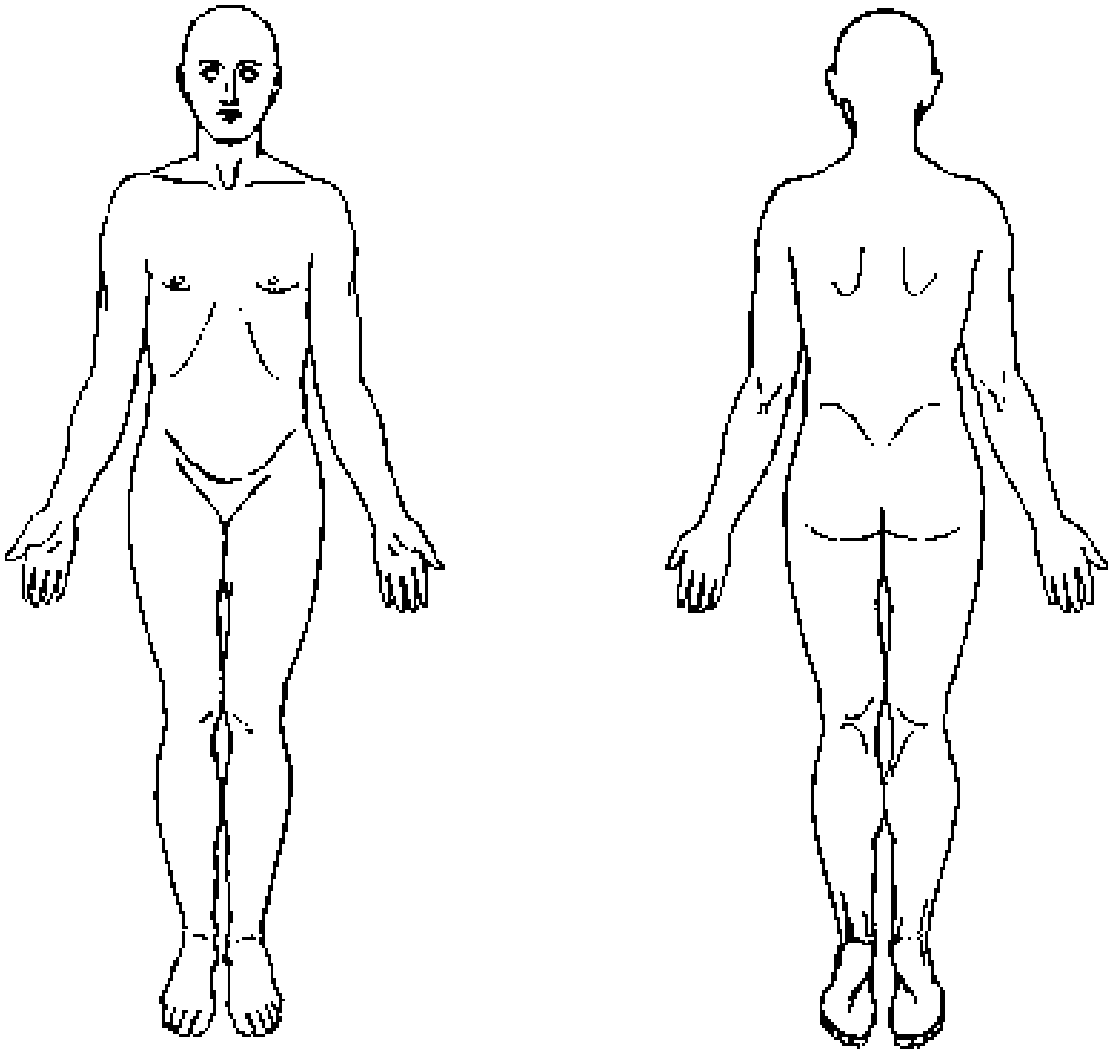
PAIN

Draw areas of pain on the body diagram ☐ Not applicable

Pain #1:
Dull / Sharp / Aching / Burning / Stabbing / Cramping / Throbbing / Tingling / Sensitive / Numb
Intensity of pain (0 = no pain, 10=worst pain ever) 0 1 2 3 4 5 6 7 8 9 10
Constant or intermittent?
What makes the pain worse?_____better?_____

Pain #2:
Dull / Sharp / Aching / Burning / Stabbing / Cramping / Throbbing / Tingling / Sensitive / Numb
Intensity of pain (0 = no pain, 10=worst pain ever) 0 1 2 3 4 5 6 7 8 9 10
Constant or intermittent?
What makes the pain worse?_____better?_____

Pain #3:
Dull / Sharp / Aching / Burning / Stabbing / Cramping / Throbbing / Tingling / Sensitive / Numb
Intensity of pain (0 = no pain, 10=worst pain ever) 0 1 2 3 4 5 6 7 8 9 10
Constant or intermittent?
What makes the pain worse?_____better?_____



SYMPTOM LIST

Height: _____ ft _____ in **or** _____cm Body weight: _____ ☐ pounds ☐ kg

Weight	decreasing	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 increasing
Appetite	decreased	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 increased
Sleep	decreased	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 increased
Mood	depressed	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 elevated
Energy level	decreased	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 increased

Do you have any of the following:	Check a box √ (0=none, 10=worst)
Fever	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Sweating	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Nausea	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Vomiting	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Food or liquid sticking when swallowing	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Pain when swallowing	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Constipation	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Diarrhea	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Cough	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Shortness of breath	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Dizziness	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Palpitations (feeling of abnormal heartbeat)	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Limb swelling ☐ legs ☐ arms	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Facial swelling	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Headache	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Numbness / tingling of hands or feet	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Any other parts of the body? (if yes, please list):	
Restlessness	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Confusion	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Memory problems	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Skin Rash	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Bleeding problems / bruising	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Urination problems	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Sexual problems	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

MISCELLANEOUS

Are you or do you think you may be pregnant? ☐ Not applicable ☐ Yes ☐ No

Are you receiving nursing care at home? ☐ Yes ☐ No ☐ Not sure

Do you have a "power of attorney" for:

Personal care? ☐ Yes (name: _____) ☐ No ☐ Not sure

Finances? ☐ Yes (name: _____) ☐ No ☐ Not sure

PRACTITIONER INFORMATION

Please provide the following information about your health care providers:

Name	Email	Specialty

Main licensed practitioner who Dr. Khan will be working with **(required)**:

Name: _____ Specialty: _____

Phone: _____ Fax: _____

Email: _____

NEOS MEDICAL

How did you find out about us?

_____

Thank you for providing this important information.

Signature: _____ **Date:** _____

Practitioner Consulting Informed Consent

All consulting, communication and information provided by Akbar Khan, MD at Neos Medical Systems are to help my licensed medical practitioner improve my health with a focus on integrative care (combination of allopathic and naturopathic medicine). I understand that integrative care is not always considered to be within the usual standards of medical care.

Consulting with Neos Medical Systems / Dr. Khan is not a replacement for medical care with a licensed medical practitioner such as a licensed medical doctor, osteopathic doctor, nurse practitioner or chiropractor. By working with Neos Medical Systems / Dr. Khan, I confirm that I have read and agree to all of the following:

- Dr. Khan is medical doctor who is not licensed. As a result, he does not diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity, or other physical or mental condition.
- There is no doctor-patient relationship with Dr. Khan.
- Health consulting services are only available in cooperation with my own licensed medical practitioner.
- The name of my main medical practitioner is_____.
- The email of my main medical practitioner is _____.
- My medical practitioner is directly supervising and controlling my medical care, including providing specific direction for diagnosis, treatment, operation, or prescription.
- My medical practitioner will be providing approval for all recommendations provided by Neos Medical Systems / Dr. Khan before I follow them, including suggested diagnoses, suggested treatment(s), suggested testing, suggested operation(s), and suggested prescription or non-prescription or natural medicine(s).
- Detailed written information and advice will be provided to my practitioner and me. My practitioner may use the information and advice in any way they deem appropriate.

I give consent to Neos Medical Systems / Dr. Khan to assist me in achieving my health goals by providing advice to me through my practitioner. I give my consent for Neos Medical Systems / Dr. Khan to use and disclose my protected health information. For complete description of such uses and disclosures, please see the Health Information Privacy pages

at https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Neos Medical Systems / Dr. Khan may call or e-mail me in reference to any items that assist me and my practitioner in carrying out healthcare services, including appointment reminders, calls pertaining to my care, and test results.

I understand that Neos Medical Systems / Dr. Khan will protect my information as confidential unless compelled to by law or unless I have given my written consent otherwise, but that the use of technology is never perfectly secure. I accept the risks of confidentiality loss in the use of email, text, phone, video call, and other technology.

I agree Neos Medical System / Dr. Khan may use my information for research and educational purposes with my identifying information removed.

I understand that the results of any suggested therapies are not guaranteed. I acknowledge that no guarantee or assurance has been made by anyone regarding any therapies.

I understand that any suggested therapies have risks and benefits. I agree that after I review the risks and benefits, I have the choice to accept the risks and receive the suggested therapies or decline the suggested therapies.

I understand that the results of any suggested medical tests are not perfectly accurate. I acknowledge that any medical test may have false positive or false negative results.

I release, waive, acquit and forever discharge Neos Medical Systems and Dr. Khan from every claim, suit action, demand or right to compensation for damages I may claim to have or that may arise as a result of our consulting relationship. No promise, inducement, or agreement not expressed herein has been made to me to sign this agreement.

I agree this agreement shall be governed and construed in accordance with the laws of the State of Florida.

_____	_____	_____
Name	Signature	Date
Akbar Khan_____	_____	_____
Neos Medical Authorized Rep	Signature	Date