Ralph T. Golan, M.D.
Family and Preventive Medicine

Ravenna Medical Arts
7522 20th Ave N.E.
Seattle, Washington 98115
Phone: (206) 524-8966
Web: www.ralphgolanmd.com

Name_____ Today's Date_____
Address_____ Occupation _____
City_____ State_____ Zip _____ Employer_____
Birthdate_____ Age _____ Medical Insurance_____
Home phone _____ Group # _____
Work phone _____ Medicare #_____
Cellphone _____ How did you hear of Dr. Golan_____
E-Mail_____ _____

All information that you volunteer will remain confidential unless you authorize its release

What do you hope to accomplish from your visits here

_____
_____
_____

What are the main problems, areas, or challenges for which you wish assistance, and for how long, approximately, have they existed? Briefly list:

1._____
2._____
3._____
4._____

What are the minor problems, areas, and challenges for which you wish assistance, and for how long approximately have they existed? Briefly list:

1._____
2._____
3._____
4._____

How would you describe your general sense of well-being?

_____
_____

What is your stamina or general energy level like?

_____

Does your energy or well-being vary with the time of day, with the weather or seasons, eating, or with any other factor of which you are aware? Describe:

_____
_____
_____

YOUR DIET

Please write down two samples of each meal (what you eat every day or nearly every day).Include what you drink with meals, desserts, and snacks:

Breakfast 1._____
2._____
Morning snack _____
Lunch 1._____
2._____
Afternoon snack _____
Dinner 1._____
2._____
Evening snack 1._____

Food Intake

For each question fill in the circle that reflects your usage most accurately

- *Dairy Products*
(milk, cheese, cottage cheese, yogurt, ice cream, goat milk, soy milk, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Eggs*

more than once a day O once a day O 2-3 times a week O less often O

-*Beans*
(Pinto, black, red, garbanzo, navy, lentil, split pea, soy, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Grains*
(Wheat, rye, corn, barley, triticale, buckwheat, millet, rice, oats, wild rice, amaranth, quinoas)

more than once a day O once a day O 2-3 times a week O less often O

-*Uses of Grains*
(Bread, rolls, muffins, scones, crackers, tortillas, pasta/noodles, cereals, bagels, pretzels, pastries, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Whole Grains (unrefined, unprocessed)*
(whole wheat bread, whole wheat pasta, whole wheat rolls, brown rice, whole grain crackers, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Refined or processed grains*
(white or French bread, white rolls, white rice, white flour, pasta, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*How often do you eat raw vegetables?*

more than once a day O once a day O 2-3 times a week O less often O

-*Starchy Vegetables* (Potatoes, yams, winter squash, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Fresh green leafy vegetables*
(Lettuce, spinach, kale, collard, chard, parsley, mustard greens, beat greens, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Other fresh vegetables*
(Carrots, celery, broccoli, cauliflower, cabbage, cucumber, tomato, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Sprouts*
(Alfalfa, clover, mung, sunflower, buckwheat.)

more than once a day O once a day O 2-3 times a week O less often O

-*Vegetable juices* (Carrot, tomato, greens)

more than once a day O once a day O 2-3 times a week O less often O

-*Fresh fruits*
(Apple, orange, banana, grapes, melons, pears, plums, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Dried fruits*
(Raisins, dates, figs, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Fruit juices*
(Orange, grapefruit, apple, berry)

more than once a day O once a day O 2-3 times a week O less often O

-*Seeds and Nuts*
(Sunflower, sesame, almond, filbert, cashew, walnut, peanut, pecan, etc)

more than once a day O once a day O 2-3 times a week O less often O

-*Meat of any kind*
more than once a day O once a day O 2-3 times a week O less often O

-*Fermented foods*
(Miso, tamari, sauerkraut, pickled vegetables, buttermilk, yogurt, kefir)

more than once a day O once a day O 2-3 times a week O less often O

-*Meals eaten out at restaurants*

more than once a day O once a day O 2-3 times a week O less often O

-*Meals eaten at "fast food" establishments*

more than once a day O once a day O 2-3 times a week O less often O

-*Pre-prepared, Frozen or TV-type dinners*

more than once a day O once a day O 2-3 times a week O less often O

-*Fried or sautéed foods*

more than once a day O once a day O 2-3 times a week O less often O

-*Soft drinks* (Coke, sprite, 7up, etc.)

more than once a day O once a day O 2-3 times a week O less often O

-*Sweets*
(Cookies, cake, pie, ice cream, candy, pastries, soft drinks, sugar cereals, etc.)
more than once a day O once a day O 2-3 times a week O less often O

How many teaspoons of sugar daily do you add to foods/beverages? _____

Coffee: Caffeinated/decaf; how many cups a day? _____

Alcoholic beverages

What kind and how many per day or week? _____

Water: Tap, filtered, spring, distilled, well/artesian; how many glasses a day _____

Other fluids not listed above_____

How many glasses a day?_____

Do you salt your food? (heavily, moderately, or not at all) _____

Do you eat highly salted foods like chips, etc.? _____

How many artificially sweetened beverages do you consume? (daily, weekly) _____

How much artificial sweetener do you add to your food/beverages daily? _____

Are you generally relaxed when you eat? _____

What is your appetite like at breakfast time? _____

At lunch time? _____

At dinner time? _____

When does your body/digestive system seem most ready for your main meal of the day?

_____

What foods or type of meals seem to make you feel or function best?

_____

What foods or beverages do you crave? _____

What kind of cooking or salad oil do you use? _____

Do you use margarine or butter? _____ How much? _____

LIFESTYLE

How much sleep do you normally get? _____ Do you awaken rested and refreshed ___

How much time every day do you spend indoors? _____ Outdoors? _____

How much physical exercise do you get, what kind, and do you feel it is sufficient?

_____

Do you smoke? ____ How much? _____ For how long have you smoked _____

Do you have any interest in quitting? _____

Do you ever fast? _____ For how long, how often, and what kind? _____

Do you meditate or do a skilled relaxation exercise? _____ how often? _____

GASTROINTESTINAL

Does food generally "sit" well in your stomach and digest without any difficulty? _____

How often do you have a bowel movement? _____

Do your bowel movements feel complete? _____

Are your bowel movements generally formed or loose? _____

Do you need to strain to have a bowel movement? _____

Do you have hemorrhoids or any other rectal or bowel problems? _____

ENVIRONMENTAL

What is the age of your current domicile? _____

Do you have a gas or electric kitchen range? _____

What kind of heat do you have? (gas, electric, oil, wood?) _____

Any recent remodeling, painting, staining, refinishing, particle board cabinets, or flooring, new carpets, glues, in the home or office? _____

Any hobbies, activities, work, or locations that expose you to fumes, exhausts, combustion products, cigarette smoke, bad air, marker pens, solvents, paints, bug spray, etc. _____

Do you seem to react adversely to any of these exposures? _____

Any placement of dental metals (fillings, crowns, implants, bridges, etc.) or root canals within 3-6 months before the onset of your symptoms? _____

MORE MEDICAL HISTORY

Please list any present illnesses/conditions not listed above:

_____

Has your weight ever been a difficult issue for you? _____ Weight change in the last six months: _____/ in the last year: _____ Current weight _____

List any drugs or medications you are taking (or have recently taken), include diet pills, birth control, aspirin, sleeping pills, anti-inflammatory pills, etc

_____
_____
_____
_____

List any vitamins or food supplements you are taking (amount in milligrams if you know)

_____
_____
_____

List any allergies or adverse reactions to inhalants, foods, medicines, perfumes, etc.

_____

Please list all surgeries, hospitalizations, and approximate dates if you can remember:

_____

_____

_____

Please list any past illnesses/conditions not listed above and approximate dates (including; thyroid problems, parasites, worms, travelers diarrhea, mono, hepatitis, chronic fatigue syndrome, ulcers, gastritis, chronic or difficult yeast problems, or any other significant condition.)

_____

_____

_____

Please list any significant injuries with approximate dates (especially head, neck and back trauma): _____

_____

When was your last general medical exam? _____
When was your last blood test? _____ Stool test? _____ Urine test? _____

Are there any significant health problems in your family?

Mother's side	Father's side	Siblings
Mother_____	Father _____	_____
Aunts _____	Aunts _____	_____
Uncles _____	Uncles _____	_____
Grandmother _____	Grandmother _____	_____
Grandfather _____	Grandfather _____	_____

Current health status of those you live with (other than those listed above):

Children _____

Others _____

_____

FEMALES

How regular are your menstrual periods? _____
Are they painful? _____ If so, please describe and include medications if applicable:

_____

Any premenstrual or ovulatory symptoms? ____ How severe? _____
Date of your last period? _____
How long do your periods last? _____
Is there any spotting or bleeding between periods? _____
Total number of years you have ever been on birth control pills: _____
When were you last taking them? _____
When was your last pelvic/pap test? _____ Results? _____
Have you ever had an abnormal pap smear previous to that last one? _____
Have you ever had a mammogram? _____ Date: _____ Results: _____
How many full term pregnancies have you had? _____

SOCIAL/PERSONAL

How do you relax and how often? _____

_____

_____

How do you feel in your home or living situations? _____

_____

_____

How do you feel in your work situations? _____

_____

_____

What do you love to do and how often do you do these things? _____

_____

_____

Do you have any goals or ambitions you would like to share with me? _____

_____

_____

What emotions/feelings/thoughts do you commonly or repeatedly have? _____

_____

_____

Is there any other information about yourself that you would like to add which would help this evaluation?

_____

_____

_____

_____

SYMPTOM SURVEY

Instructions: Grade the symptoms which apply to you with a (1) for mild or occasional; (2) for moderate or more than occasional; or (3) for severe or frequent. Some symptoms are repeated in several groupings. Although it will be repetitive, grade your in every grouping they appear. Leave blank if a symptom does not apply to you.

GROUP 1

If delayed or missed meals
__shaky or faint feeling
__fatigued or sleepy
__headaches
__depression
__anxious/nervous
__irritable or moody
__foggy/fuzzy brain
__can't work under pressure
__heart palpitations

Unrelated to meals
__insomnia
__caffeine or sugar cravings
__alcoholic or recovered alcoholic.

GROUP2

__fatigue
__frequent infections
__depression
__headache
__foggy headed
__poor memory
__hyperactivity/ learning disorder.
__diarrhea or constipation?
__gas/bloating
__arthritis/joint pain
__muscle pains
__frequent urination
__heart palpitations
__sore throat
__sinus trouble
__dark circles under eyes
__seizures
__ringing in the ears
__seizures
__less interest in sex
__hair loss
__infertility
__multiple miscarriages
__slow pulse
__water retention or edema
__carpel tunnel syndrome
__decreased sweating
__headaches often upon arising, later wear off.
__family member with low thyroid condition or who takes thyroid medication.
__dizziness
__high blood cholesterol

GROUP 3

__persistent sinus problems
__persistent throat irritations
__gas or bloating
__diarrhea or constipation
__vaginal yeast infections
__bladder infections
__premenstrual syndrome
__menstrual cramps
__fatigue
__recurrent colds, flus, etc.
__arthritis or joint pains
__muscle pains
__headaches
__depression
__chemical intolerance: can't handle fumes, exhausts, perfumes, smoke, etc.
__multiple food allergies
__lots of antibiotic
__more tan 2 years of birth control, past or now.
__cortisone or prednisone use
__chemotherapy
__rash or itching, anywhere
__fungal infections of the skin or nails.
__asthma
_coated tongue or thrush
__intolerance to alcoholic beverages.
__recurrent prostatitis

GROUP 4

__fatigue, physical
__fatigue, mental
__reduced initiative
__poor memory
__depression
__weight gain
__difficulty losing weight
__sensitive to cold
__cold hands and feet
__constipation
__dry or course skin
__menstrual cramps
__too heavy or too light menstrual periods
__premenstrual syndrome
__recurrent or prolonged respiratory infections
__impotence

GROUP 5

__depression
__irritability/anxiety
__hyperactivity
__behavioral abnormalities
__learning disability
__bad memory/concentration
__high blood pressure
__fatigue
__poor intellectual or academic performance
__abdominal pain
__anemia
__neuropathy/neuritis/ numbness/burning
__tremor/twitches/seizures
__heart palpitations
__recurrent infections
__miscarriages?stillbirths
__weakness
__headache
__rash
__recurrent infections

GROUR 7
__fatigue
__depression
__bad memory/concentration
__nervous/irritable
__awaken tired, unrefreshed
__feel exhausted at night, but too wired to sleep
__any sleep disturbance
__slow recovery from any stress: a late night, physical workout, argument, etc.
__low or no reserve
__easily overwhelmed
__easy injuries, slow healing
__allergies: inhalants, foods, chemicals
__recurrent infections
__headaches
__low blood pressure
__lightheaded on standing up
__diminished perspiration
__low body temperature
__hypoglycemia
__history of extreme or prolonged stress
__history of trauma,prolonged pain or inflammation
__history of chronic infection
__premenstrual syndrome
__hair loss
__osteoporosis

GROUP 10
__diarrhea
__constipation
__nausea
__poor appetite
__vomiting
__excessive gas
__bloating
__abnormally smelly stools
__bloody stools
__abdominal cramps or pain
__weight loss or difficulty gaining weight
__food allergies/intolerance
__asthma
__hives
__autoimmune disease
__irritable bowel
__difficulty overcoming yeast growth
__difficulty overcoming food allergies and intolerance

GROUP 8
__fatigue
__weakness
__depression
__apathy/lethargy
__hyperactivity
__headache
__insomnia
__poor memory
__confusion
__difficulty making decisions
__dizziness
__tinnitus/ear ringing
__diarrhea/constipation
__bloating
__achy muscles or joints
__acne
__itching
__hives or other rashes
__frequent urination
__water retention
__allergies
__frequent infections

GROUP 11
__diarrhea
__greasy or floating stools
__unsettled stomachs
__irritable bowel
__undigested food in stool
__weight loss or hard to gain
__hypoglycemia
__acne
__food intolerance

GROUP 10 CONTINUED….
__history of foreign travel
__traveler's diahhrea
__drinking untreated water camping, swimming, traveling
__history of parasites; treated or untreated
__unexplained fever rheumatoid or other "immunological" arthritis
__low white blood cell count
__elevated eosinophil count
__household member or sex partner with parasite or bowel symptoms

FOR MEN
__difficult urination
__excess dribbling

GROUP9
__heartburn or acid indigestion
__food just sits there in stomach
__get full to easily
__food feels heavy in stomach
__bloated after meals
__excessive gas
__constipations or IBS
__coated tongue
__bad breath
__stool abnormality, smelly
__weak, thin, cracked or peeling finger nails
__muscle cramps or spasms
__food allergies
__intestinal yeast
__osteoporosis
__hypoglycemia

FOR WOMEN *menstrual or premenstrual*
__depression
__felling fragile
__weight gain
__water retention
__headaches
__cravings: sugar, salt chocolate, etc.
__cystic breasts
__constipation or diarrhea
__uterine cramps
__irritable, moody
__bloating __breast pain
__acne __insomnia
__fatigue __back pain

MENOPAUSAL
__hot flashes __mood swings
__dry or irritated vagina
__sleep disturbance
__poor memory __low libido
__difficulty concentrating
__osteoporosis
__headaches
__urinary frequency

FOR MEN CONTINUED….
__frequent nighttime urination
__less desire for sex
__rectal, pubic or scrotal pain
__erection problems

OFFICE POLICY ON FEES, PAYMENT AND INSURANCE

Dr. Golan's initial comprehensive evaluation usually requires from one to three hours and his hourly rate is $540.00. The usual time for followup consultations is 30 minutes however, complex medical issues or multiple laboratory reports to review may require additional time. Time beyond the usual 30 minutes will be charged at a prorated rate based on Dr Golan's hourly fee. (Please see our cancellation policy below.)

Any laboratory fees, vitamin injections, and nutritional supplements will be in addition to the visit fees.

We ask that your payment be made at the time of each visit (cash, check, Visa, Mastercard). We will provide you with a statement of services and payments which you may submit to your insurance carrier.

Fees for phone consultations will be handled at the time of service by credit card. Fees for reports completed on your behalf by Dr Golan are charged at a lower rate, and determined by the time necessary for the completion of reports.

Dr. Golan is not a participant with any managed care or HMO organizations and is not a participating provider with any insurance companies. Those companies which restrict coverage only to participating physicians will not likely reimburse you for any of Dr. Golan's services. Some insurance carriers, however, will cover services from non-participating physicians, but at a lower percentage rate. Check with your insurance carrier for coverage details. Insurance carriers without a restrictive physician list will reimburse Dr. Golan's services at their customary out of network rate.

REGARDING MEDICARE

Any services, laboratory costs or nutritional therapies for individuals whose primary insurance is Medicare will not be able to seek reimbursement whatsoever from Medicare. This office does not bill Medicare, nor can patients bill Medicare themselves. Medicare patients and Dr. Golan are, by law, required to sign a "Private Contract" which we will provide. If you have private primary insurance and Medicare is secondary, you may be able to seek reimbursement depending on your particular primary coverage (see above paragraph). Whether Medicare is primary or secondary, we ask that payment for all services be made at the time of each visit.

Our labs may be able to bill your insurance company directly for lab tests depending on the test in question. However, a $20.00 blood draw fee would be incurred if applicable. We recommend that some tests be prepaid along with submitted samples and that you submit the charges to your insurance.

CANCELLATION POLICY

If you need to cancel a new patient appointment, please give us at least 48 hours or more notice so that we may be able to offer your time to someone else. If you have a new patient appointment on a Monday that you need to change or cancel, and as we are not in the office on Fridays, we would ask that you call before 5:00 pm on the Thursday before your Monday appointment. For follow up appointments, please give us at least 24 hours notice of cancellation. If you do not give us this adequate notice of cancellation, we reserve the right to bill you for Dr. Golan's lost time.

Signature _____ Date _____

RALPH T GOLAN MD

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

RAVENNA MEDICAL ARTS
7522 20TH AVENUE NORTHEAST
SEATTLE WASHINGTON 98115
TELEPHONE 206 524 8966

RALPH T GOLAN MD

CONSENT FORM

Under the state of Washington statutes regulating the practice of medicine, some of the testing and treatment methods I recommend may be considered "experimental" and "unproven". My recommendations to you come from a synthesis of both my conventional, allopathic medical training and my experience and research of "alternative" methods and modalities such as herbal medicine, vitamin and other nutritional supplementation (oral, intramuscular, and/or intravenous), detoxification regimens, bee venom injection, mesotherapy, chelation, plaquex, acupuncture, kinesiology (muscle testing), and other approaches — all of which I have experienced myself and consider safe and effective. Nevertheless, any prescription whether a plant, animal extract, pharmaceutical drug, or procedure when appropriately prescribed or performed may not bring the expected results and/or may cause allergic, idiosyncratic (unique to the individual), or other adverse reactions such as (but not limited to): gastrointestinal upsets, headaches, skin eruptions, mood changes, or dysfunction in any organ or system of the body.

Ralph Golan, MD

I have read the above paragraph and am aware that some of the testing and treatment recommendations Dr. Golan has given me may be considered experimental and different from standard allopathic medical testing and treatment. I also understand the benefits, risks and limitations of the testing and treatment recommended to me and consent to and choose such testing and treatment. Regarding the purchase of nutritional supplements, my signature below also represents my understanding that I am in no way obligated to purchase nutritional supplements from Dr. Golan's office and that I have been given contact information to purchase these items elsewhere if I so desire.

Signature of patient or person authorized to sign for patient Date

Signature of witness Date

I have carefully explained to this patient the nature of this treatment. I hereby certify that to the best of my knowledge the patient who is signing this consent form understands clearly the nature, demands, benefits, risks and choices involved in his/her participation. A medical problem or language or educational barrier has not precluded this understanding.

Ralph Golan, MD Date

RAVENNA MEDICAL ARTS
7522 20TH AVENUE NORTHEAST
SEATTLE WASHINGTON 98115
TELEPHONE 206 524 8966

RALPH T GOLAN MD

CONSENT FORM FOR AUTONOMIC REFLEX TESTING AND FOR QUANTUM REFLEX ANALYSIS

Autonomic Reflex Testing (ART) and Quantum Reflex Analysis (QRA) are forms of muscle testing (kinesiology) that can help determine underlying imbalances in the body. It is a system that provides information about organs, glands and other parts of the body and provides indications that can lead to treatment choices (prescription medications, vitamins, minerals, herbal and nutraceutical formulas, and other nutritional supplements, as well as mineral-clay-herb packs applied externally to the body.

ART and QRA cannot substitute for a conventional medical examination and laboratory testing and can miss diagnoses that a conventional medical evaluation could disclose—for example cancer, heart disease, diabetes, Alzheimer's disease, multiple sclerosis, etc. Conversely, performing an ART and QRA evaluation gives Dr. Golan diagnostic and treatment information that a conventional medical evaluation may not provide. Dr Golan finds that kinesiology and a conventional medical evaluation complement each other in important ways and lead to better patient outcomes.

Your signature below represents that you understand the limitations of ART and QRA and that you choose to undergo this evaluation with Dr. Golan. Your signature also represents that you have been given the option to purchase any recommended products elsewhere and are under no obligation whatsoever to purchase them from Dr. Golan,

_____ _____

Signature of patient Date

_____ _____

Ralph Golan, MD Date

RAVENNA MEDICAL ARTS
7522 20TH AVENUE NORTHEAST
SEATTLE WASHINGTON 98115
TELEPHONE 206 524 8966

RALPH T GOLAN MD

CONSENT AND DISCLOSURE

There are inherent limitations in phone consultations, particularly for new patient evaluations, as I am unable obviously to perform an examination or have face to face contact that is so important in gaining information and in developing a relationship. I prefer, therefore, to have the first visit at least in person and follow-up visits could more easily be conducted by phone.

If traveling to Seattle is entirely impossible, however, I would be willing to do phone consultations with new patients because and exchange of verbal information is still worthwhile, and we have found that such consultations have resulted in benefit to patients.

Understand, however, that this type of consultation cannot substitute as a medical evaluation. It is consultative health advice that I offer upon your signature below.

I certify that I understand that phone consultations with Dr. Golan do not substitute for an in person medical evaluation and I hold Dr. Golan harmless for any potential missed or incorrect diagnoses.

_____ _____

Signature of patient or person authorized to sign Date

_____ _____

Ralph T. Golan, M.D.

RAVENNA MEDICAL ARTS
7522 20TH AVENUE NORTHEAST
SEATTLE WASHINGTON 98115
TELEPHONE 206 524 8960

Ralph Golan, M.D.

7522 20th Ave. NE
Seattle, Wa 98115
206-524-8966

Informed Consent for Treatment of Lyme Disease (and co-infections such as Babesiosis, Bartonellosis Erlichiosis and others)

There is considerable uncertainty regarding the diagnosis and treatment of Lyme disease. No single diagnostic and treatment program from Lyme disease is universally successful or accepted. Medical opinion is divided, and two schools of thought regarding diagnosis and treatment exist. Each of the two schools of thought is described in peer-reviewed, evidence-based treatment guidelines. Until we know more, patients must weigh the risks and benefits of treatment in consultation with their doctor.

My Diagnosis. The diagnosis of Lyme disease is primarily a clinical determination made by my doctor based on my exposure to ticks, my report of symptoms, and my doctor's observation of signs of the disease, with diagnostic tests playing a supportive role.

Doctors differ in how they diagnose Lyme disease.

- Some physicians rely on the narrow surveillance case criteria of the CDC for clinical diagnosis even though the CDC itself cautions against this approach. These physicians may fail to diagnose some patients who actually have Lyme disease. For these patients, treatment will either not occur or will by delayed.
- Other physicians use broader clinical criteria for diagnosing Lyme disease. These physicians believe it is better to err on the side of treatment because of the serious consequences of failing to treat active Lyme disease. These physicians sometimes use the antibiotic responsiveness of a patient to assist in their diagnosis. Since no treatment is risk-free, use of broader clinical criteria to diagnose disease could in some cases expose patients to increased treatment complications. This approach may result in a tendency to over diagnose and over treat Lyme disease.

My Treatment Choices. The medical community is divided regarding the best approach for treating persistent Lyme disease. At this time the majority of physicians follow the treatment guidelines of the Infectious Disease Society of America, which recommend short term treatment only and view the long-term effects of Lyme disease as an autoimmune process or permanent damage that is unaffected by antibiotics. Other physicians believe that the infection persists, is difficult to eradicate, and therefore requires long-term treatment with intravenous, intramuscular, or oral antibiotics, frequently in high and/or combination doses.

Potential Benefits of Treatment. Some clinical studies support longer term treatment approaches, while others do not. The experience in this office is that although most patients improve with continued treatment, some do not.

Risks of Treatment. There are potential risks involved in using any treatment, just as there are in foregoing treatment entirely. Some of the problems with antibiotics may include (a) allergic reactions, which may manifest as rashes, swelling, and difficulty with breathing, (b) stomach or bowel upset, or (c) yeast infections. Severe allergic reactions may require emergency treatments, while other problems may require suspension of treatment, or adjustment of medication. Other problems such as adverse effects on liver, kidneys gallbladder, or other organs may occur.

Factors to consider in my decision. No one knows the optimal treatment of symptoms that persist after a patient is diagnosed with Lyme disease and treated with a simple short course of antibiotic therapy. The appropriate treatment may be supportive therapy without the administration of any additional antibiotics. Or, the appropriate treatment might be additional antibiotic therapy. If additional antibiotic therapy is warranted, no one knows for certain exactly how long to give the additional therapy. By taking antibiotics for longer periods of time, I place myself at greater risk of developing side effects. By stopping antibiotic treatment, I place myself at a greater risk that a potentially serious infection will progress. Antibiotics are the only form of treatment shown to be effective for Lyme disease, but not all patients respond to antibiotic therapy. There is no currently available diagnostic test that can demonstrate the eradication of the Lyme bacteria from my body. Other forms of treatment designed to strengthen my immune system also may be important. Some forms of treatment are only intended to make me more comfortable by relieving my symptoms and do not address any underlying infection.

My decision about continued treatment may depend on a number of factors and the importance of these factors to me. Some of these factors include (a) the severity of my illness and degree t which it impairs my quality of life, (b) whether I have co-infections, which can complicate treatment, (c) my ability to tolerate antibiotic treatment and the risk of major and minor side effects associated with the treatment, (d) whether I have been responsive to antibiotics in the past, (e) whether I relapse or my illness progresses when I stop taking antibiotics, and (f) my willingness to accept the risk that, left untreated, a bacterial infection potentially may get worse.

For example, if my illness is severe, significantly affects the quality of my life, and I have been responsive to antibiotic treatment in the past, I may wish to continue my treatment. However, if I am willing to accept the risk that the infection may progress or if I am not responsive to antibiotics, I may wish to terminate treatment. I will ask my doctor if I need any more information to make this decision and am aware that I have the right to obtain a second opinion if I think this would be helpful.

My questions have all been answered in terms I understand, I am aware of the risks involved in antibiotic and in foregoing antibiotic treatment. Based on this information, I have decided: (CHECK ONE)

(and/or coinfections as above)

- o To treat my Lyme disease with antibiotics until my clinical symptoms resolve.
- o Only treat my Lyme disease with antibiotics for thirty days, even if I still have symptoms.

o Not to pursue antibiotic therapy. To my knowledge, I am not allergic to any

medications except those listed below:

I understand the benefits and risks of the proposed course of treatment, and of the alternatives to it, including the risks and benefits of foregoing treatment altogether. My questions have all been answered in terms I understand. All blanks on this document have been filled in as of the time of my signature.

Signature_____ Date_____

Print name_____
:

Witness_____ Date_____