

**Center for Holistic Medicine
Medical Follow Up**

Name: _____

Date: ___/___/___

1. General update, progress, setbacks, lists of concerns/biggest issues.

2. Current detailed list of supplements and medications (brand - dosages-frequencies), bad reactions.

3. Current bowel/bladder complaints and sleep patterns.

4. Current dietary regimen (i.e. Elimination diet, gluten/dairy restriction etc)

5. Current therapies or outside medical evaluations in progress/pending.

