

Application for Admission
Type II Diabetes Case History

If you are reading this you have been fortunate enough to qualify for a **consultation** with Dr. Branham at no charge.

This however does NOT mean that your case has been accepted.

Your consultation today will determine if:

A) You are a legitimate candidate for this program and B) You are serious enough about your condition to warrant your case being accepted for treatment. In the event that Dr. Branham is UNAVAILABLE to provide care to you, your case will be referred to another clinic.

Today's Date _____

Name _____ Age _____ Birthday _____ Sex M / F

Address _____

City _____ State _____ Zip _____ SS# _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Place to Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes / No

Employer _____ Occupation _____

E-mail _____ Would you like to receive e-mail updates? Yes / No

Marital Status S M W D Spouses Name _____

I (signature) _____ consent to allow Dr. Branham to speak with me and perform an examination if necessary, in order to determine if I am a good candidate for care and also to determine if he is willing to accept my case. It is also my understanding that BOTH the consultation AND examination (if necessary) are at no charge.

How Did You Hear About Dr. Branham? Referred by: _____ TV Show _____ Other _____

1. How Serious Do You Think Your Problem Is?

What Is Your Main Problem(s)/Symptom(s) Prompting Your Request For A Consultation With The Doctor?

Would You Consider This Problem (circle one)....

MINIMAL (Annoying but causing NO limitations)

SLIGHT (Tolerable but causing a little limitation)

MODERATE (Sometimes tolerable but definitely causing limitations)

SEVERE (Causing Significant limitations)

EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and in your own opinion what do you think the real problem is?

2. When was the first time you had a Diabetic symptom, please describe?

3. When were you given an official diagnosis of Type II Diabetes?

4. What diagnostic tool(s) were used to achieve that diagnosis?

5. Since your type II diabetes began what three things has it caused you to miss the most?

6. What kinds of treatments have you received?

Prescriptions or Drug Therapy _____
Nutritional Therapy _____
Alternative or Holistic Therapy _____
Surgery _____

7. When did you receive these treatments and for how long?

8. Did any of these treatments work? If so which one(s)? For how long?

9. Please list all prescription medications, over the counter drugs and supplements (vitamins) you are currently taking.

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

10. Is there anything you have done on your own, outside of medical advice that improved your condition?

11. What activities or situations are guaranteed to make it worse?

12. Are your diabetic symptoms worse in the morning or is it worse as the day progresses?

13. If you cannot find a solution to this problem what do you think will happen to you?

14. What are you hoping Dr. Branham tells you today?

15. Describe what you hope or think he might be able to do for you.

16. Describe what will be different in your life if you can get better.

When is the VERY FIRST time you recall having this problem?

List, In Order of Importance, OTHER Health Problems/Concerns NOT including Your Main Problem Above.

- | | |
|----------|-----------------------------------|
| 1. _____ | How Long Have You Had This? _____ |
| 2. _____ | How Long Have You Had This? _____ |
| 3. _____ | How Long Have You Had This? _____ |
| 4. _____ | How Long Have You Had This? _____ |

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem? (circle one)

Occasionally (25% of the time)

Intermittently (50% of the time)

Frequently (75% of the time)

Constant (90-100% of the time)

Due To Your Main Problem.....

Have You Lost Any Time From Work? Yes No

How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Chores/Tasks At Home? Yes No

How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Family? Yes No

How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc...)

How Much Time and What Tasks Have Been Limited?

The HIGHEST your blood sugar gets WITHOUT medication _____

The LOWEST your blood sugar gets WITHOUT medication _____

The HIGHEST your blood sugar gets WITH medication _____

The LOWEST your blood sugar gets WITH medication _____

List ANY surgeries that you have had and the corresponding dates.

Have you had ANY of the following in the last 12 months or currently.
(Mark C for Current. X for in last 12 mos.)

GENERAL

Chills ____ Convulsions ____ Dizziness ____ Fainting ____ Fatigue ____ Fever ____ Headache ____
Loss of Sleep ____ Allergy ____ (to what ____) Loss of Weight ____ Nervousness ____
Wheezing ____ Bronchitis ____
Numbness in BOTH hands AND feet ____

CARDIOVASCULAR

High Blood Pressure ____ Low Blood Pressure ____ Pain over heart ____ Poor Circulation ____ Rapid
Heartbeat ____ Previous Heart Problem ____ (Describe ____) Slow Heartbeat
____ Stroke ____ TIA ____ Swollen Ankles ____ Varicose Veins ____ Aortic Aneurysm ____ Bruise
Easily ____

DISEASES/CONDITIONS

Appendicitis ____ Anemia ____ Arthritis ____ Alcoholism ____ Abdominal Surgery ____ Bleeding
Disorder ____ Blood Clot(s) ____ Breathing Difficulty ____ Cancer ____ Cholesterol High ____ Colon
Problems ____ Diabetes ____ Depression ____ Epilepsy ____ Eczema ____ Eating Disorder ____
Glaucoma ____ HIV + ____ Heart Disease ____ Hernia ____ Headaches ____ Influenza ____ Kidney
Disease ____ Liver Disease ____ Low back Pain ____ Mental Illness ____ Measles ____ Mumps ____
Pleurisy ____ Pneumonia ____ Polio ____ Prostate Problems ____ Hyperthyroid ____ Hypothyroid ____
Rectal Surgery ____

EARS/EYES/NOSE/THROAT

Asthma ____ Crossed Eyes ____ Double Vision ____ Blurred Vision ____ Difficulty Swallowing
____ Deafness ____ Hearing Loss ____ Ear Pain ____ Thyroid Problem ____ Nose Bleeds ____ Sinus
Problems ____ Sore Throats ____

GASTRO-INTESTINAL

Gas ____ Colon Trouble ____ Constipation ____ Diarrhea ____ Gallbladder Trouble ____ Hemorrhoids
____ Liver Trouble ____ Nausea ____ Stomach Ache ____ Poor Appetite ____ Poor Digestion ____
Vomiting ____ Vomiting Blood ____ Rectal Bleeding ____ Bloating ____

GENITO-URINARY

Blood in Urine ____ Frequent Urination ____ Inability to control urine ____ Kidney Infection ____ Painful
Urination ____ Prostate Trouble ____ Painful Urination ____

FOR MEN ONLY

Lump in testicles ____ Penis discharge ____

FOR WOMEN ONLY

Menstrual Cramps ____ Excessive menstrual flow ____ Hot Flashes ____ Irregular Cycle ____ Painful
periods ____ Birth Control Pills ____ Abnormal Pap Smear ____

MUSCLE/JOINT/BONE

Backache ____ Foot Trouble ____ Pain between Shoulders ____ Painful Tailbone ____ Stiff Neck
____ Spinal Curvature ____ Swollen Joints ____

NEUROLOGIC

Seizures ____ Dizziness ____ Hand Trembling ____ Weakness ____ Difficulty with speech ____ Loss of
memory ____ Loss of coordination ____

RESPIRATORY

Chest Pain ____ Chronic Cough ____ Difficulty Breathing ____ Coughing/Spitting Blood ____