



Circle of Life Family Medicine

Name: _____

Date Form Completed: _____

Address: _____

Date of Birth: _____

Phone #: _____

Medical Insurance #1: _____

ID #: _____

Medical Insurance #2: _____

ID #: _____

Dear Sir/Madam:

Thank you for your interest in our practice. In order for us to get a complete understanding of your symptoms, please answer the following questions.

1. What symptoms do you have that makes you believe you have lyme disease or another tick borne illness?

2. Have you been **tested** for lyme disease or another tick borne illness in the past?
 - a. If so, when and where?

 - b. What was the result of that test?

3. Have you been **treated** for lyme disease or another tick borne illness in the past?
 - a. If so, when and where?

 - b. What treatment did you undergo?

4. What are your expectations from the visit?

Once we receive this completed form back from you and review it, someone from our office will be in touch to discuss the next steps.

Sincerely,

Drs. Jennifer and Christopher Pichay
/Ima