South Denver Internal Medicine
A Concierge Medical Practice at Sky Ridge Medical Center
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ANNUAL PREVENTIVE HEALTH HISTORY

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Name: Date:

DO YOU HAVE ANY HEALTH CONCERNS?

1. NUTRITION

Describe a typical day of eating:
Breakfast:
Morning Snack:
Lunch:
Afternoon Snack:
Dinner:
Do you crave Sugar? Yes No Do you crave Carbohydrates? Yes No
Do you crave Salt? Yes No
Are you portion sizes large? Yes No
Do you skip Breakfast? Yes No Do you skip other meals throughout the day? Yes No
Do you eat 3 hours or less prior to going to sleep? Yes No
How many times a week do you eat packaged/processed foods?
Do you eat white breads, white rice/ white pasta? Yes No
Do you drink fruit juices? Yes No Do you eat Fast Food? Yes No
Do you drink energy drinks? Yes No How much?
Do you drink coffee? Yes No Tea? Yes No
What do you add to your coffee or tea?
Do you use artificial sweeteners? Which ones?
How much water do you drink a day?
How many servings of fruits do you eat per day?
How many servings of vegetables do you eat per day?

2. EXERCISE

Do you exercise regularly?	Yes O No O	If you answered "No" please note why?	
Do you perform cardiovascular exercises?	Yes O No O	Circle the types:	Walking Treadmill Elliptical Bicycle Running Yoga Other:
Do you perform strength training exercises?	Yes O No O	Circle the types:	Weights Yoga Other:
Do you perform stretching, flexibility or balance training exercises?	Yes O No O	Circle the types:	Yoga Other:
How many minutes do you exercise per session?	10 20 30 40 50 60 >60 Other:		
How many days per week do you exercise?	0 1 2 3 4 5 6 7		

3. SLEEP

How many hours do you sleep for?	<5 6 7 8 9 >10		
How long does it typically take you to fall asleep?	<15 min 30 min 45 min 60 min >60 min		
Do you take anything to help you sleep?	Yes O	No O	Describe what you take?
Do you typically wake up in the middle of the night?	Yes O	No O	Describe why?
Do you typically go right back to sleep after you wake up?	Yes O	No O	Describe why you may not?
Do you snore?	Yes O	No O	
Do you typically wake up tired?	Yes O	No O	
Do you take naps during the day?	Yes O	No O	What time of the day and for how long?

4. EMOTIONAL HEALTH

Do you or have you recently felt depressed?	Yes O	No O	Describe:
Do you or have you recently felt anxious?	Yes O	No O	Describe:
Do you have any major stressors in your life?	Yes O	No O	Describe:

5. HEALTH AND FITNESS GOALS

What are your 2 main health and fitness goals?

a.

Why is this important to you?

What keeps you from attaining this?

b.

Why is this important to you?

What keeps you from attaining this?

Are you currently following a nutrition plan?

Do you gain weight easily?

Do you tend to go on and off diets?

Do you have a hard time losing weight?

How long has it been since you were at your ideal weight?

6. HEALTH SCREENING

Test	Date last performed		Test	Date last performed
Bone Density			Dermatology Exam	
Breast Exam			Eye Exam	
Calcium Heart Score			Mammogram (women only)	
Colonoscopy			Pap smear (women only)	
Dental Exam				

7. RISK FACTORS

Do you drink alcohol?	Yes O	No O	How many drinks per week?
Do you drink caffeine?	Yes O	No O	How many cups per day?
Do you use illicit drugs?	Yes O	No O	Describe:
Do you use tobacco products?	Yes O	No O	How many packs per day?