

Name:

Date:

Do you have any current health concerns?

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## 1. NUTRITION

Do you follow a special diet?	Yes <input type="radio"/>	No <input type="radio"/>	Describe:		
What do you typically eat for breakfast?					
What do you typically eat for lunch?					
What do you typically eat for dinner?					
Do you typically drink 5–8 glasses of water per day?	Yes <input type="radio"/>	No <input type="radio"/>			
Do you typically snack during the day?	Yes <input type="radio"/>	No <input type="radio"/>	Describe your snacks:		
How would you describe your portion sizes?	Small <input type="radio"/>	Medium <input type="radio"/>	Large <input type="radio"/>	Other:	
Indicate how many servings of fruits <i>and</i> vegetables you have per day?				One Serving= 1 cup green leafy vegetable or ½ cup raw or cooked vegetable or ¼ cup dried fruit or 1 small piece fruit or ½ cup chopped fruit.	

## 2. EXERCISE

Do you exercise regularly?	Yes <input type="radio"/>	No <input type="radio"/>	If you answered "No" please indicate why?			
Do you perform cardiovascular exercises?	Yes <input type="radio"/>	No <input type="radio"/>	Walking <input type="radio"/>	Treadmill <input type="radio"/>	Elliptical <input type="radio"/>	Bicycle <input type="radio"/>
			Running <input type="radio"/>	Yoga <input type="radio"/>	Other:	
Do you perform strength training exercises?	Yes <input type="radio"/>	No <input type="radio"/>	Weights <input type="radio"/>	Yoga <input type="radio"/>	Pilates <input type="radio"/>	Other:
Do you perform stretching, flexibility or balance training exercises?	Yes <input type="radio"/>	No <input type="radio"/>				
How many minutes do you exercise per session?	10 minutes <input type="radio"/>	20 minutes <input type="radio"/>	30 minutes <input type="radio"/>	40 minutes <input type="radio"/>		
	50 minutes <input type="radio"/>	60 minutes <input type="radio"/>	> 60 minutes <input type="radio"/>			
How many days per week do you exercise?	1 day <input type="radio"/>	2 days <input type="radio"/>	3 days <input type="radio"/>	4 days <input type="radio"/>		
	5 days <input type="radio"/>	6 days <input type="radio"/>	7 days <input type="radio"/>			

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Patient Name:

### 3. SLEEP

How many hours do you sleep?

How long does it typically take you to fall asleep?	<15 min <input type="radio"/>	20 min <input type="radio"/>	30 min <input type="radio"/>	45 min <input type="radio"/>	60 min <input type="radio"/>	>60 min <input type="radio"/>
Do you take anything to help you sleep?	Yes <input type="radio"/>	No <input type="radio"/>	Describe what you take?			
Do you typically wake up in the middle of the night?	Yes <input type="radio"/>	No <input type="radio"/>	Describe why?			
Do you typically go right back to sleep after you wake up?	Yes <input type="radio"/>	No <input type="radio"/>	Describe why you may not?			
Do you snore?	Yes <input type="radio"/>	No <input type="radio"/>				
Do you typically wake up tired?	Yes <input type="radio"/>	No <input type="radio"/>				
Do you take naps during the day?	Yes <input type="radio"/>	No <input type="radio"/>	What time of the day and for how long?			

### 4. EMOTIONAL HEALTH

Do you or have you recently felt depressed?	Yes <input type="radio"/>	No <input type="radio"/>	Describe:
Do you or have you recently felt anxious?	Yes <input type="radio"/>	No <input type="radio"/>	Describe:
Do you have any major stressors in your life?	Yes <input type="radio"/>	No <input type="radio"/>	Describe:

### 5. VACCINATIONS: Have you received any NEW vaccines in the PAST YEAR?

Vaccine	Date last given	Vaccine	Date last given
COVID-19: Brand:		Prevnar 13 (Pneumonia)	
Influenza:		Shingrix (Shingles)	
Pneumovax (Pneumonia)		Tetanus (Td or Tdap)	

### 6. HEALTH SCREENING: Have you received any health screenings in the LAST YEAR?

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

### 7. RISK FACTORS

Do you drink alcohol?	Yes <input type="radio"/>	No <input type="radio"/>	How many drinks/week?
Do you drink caffeine?	Yes <input type="radio"/>	No <input type="radio"/>	How many cups/day?
Do you use tobacco products?	Yes <input type="radio"/>	No <input type="radio"/>	Describe:
Do you drink sugary soft drinks?	Yes <input type="radio"/>	No <input type="radio"/>	How many/week?

**Patient Name:**

**Mark if you CURRENTLY have or recently have had any of the following symptoms.**

<b>GENERAL</b>		<b>HEART</b>		<b>URINARY</b>		<b>PSYCHIATRY</b>	
Abnormal bleeding	<input type="radio"/>	Chest discomfort	<input type="radio"/>	Blood in urine	<input type="radio"/>	Anxiety	<input type="radio"/>
Abnormal bruising	<input type="radio"/>	Chest pain	<input type="radio"/>	Inability to control bladder	<input type="radio"/>	Depression	<input type="radio"/>
Chills	<input type="radio"/>	Difficulty breathing @ night	<input type="radio"/>	Inability to empty bladder	<input type="radio"/>	Hallucinations	<input type="radio"/>
Cold intolerance	<input type="radio"/>	Exercise intolerance	<input type="radio"/>	Frequent urination	<input type="radio"/>	Suicidal thoughts	<input type="radio"/>
Dizziness	<input type="radio"/>	Leg cramps exercise	<input type="radio"/>	Genital sores	<input type="radio"/>	Violent thoughts	<input type="radio"/>
Fainting episodes	<input type="radio"/>	Palpitations/racing heart	<input type="radio"/>	Lack of sexual drive	<input type="radio"/>	<b>MEN ONLY</b>	
Fatigue	<input type="radio"/>	Short of breath exercise	<input type="radio"/>	Nighttime urination	<input type="radio"/>	Erection problems	<input type="radio"/>
Fever	<input type="radio"/>	Swelling (legs or feet)	<input type="radio"/>	Painful urination	<input type="radio"/>	Lump in testicle	<input type="radio"/>
Flushing	<input type="radio"/>	<b>LUNGS</b>		Urinary urgency	<input type="radio"/>	Penis discharge	<input type="radio"/>
Heat intolerance	<input type="radio"/>	Breathing problems	<input type="radio"/>	Weak urinary stream	<input type="radio"/>	Sore on penis	<input type="radio"/>
Loss of appetite	<input type="radio"/>	Cough	<input type="radio"/>	<b>MUSCLES AND JOINTS</b>		<b>WOMEN ONLY</b>	
Lymph node large	<input type="radio"/>	Coughing up blood	<input type="radio"/>	Back pain	<input type="radio"/>	Abnormal PAP	<input type="radio"/>
Night sweats	<input type="radio"/>	Short of breath	<input type="radio"/>	Joint pain	<input type="radio"/>	Breast lump	<input type="radio"/>
Sleep disturbance	<input type="radio"/>	Snoring	<input type="radio"/>	Joint swelling	<input type="radio"/>	Breast pain	<input type="radio"/>
Thirst excessive	<input type="radio"/>	Sputum	<input type="radio"/>	Morning stiffness	<input type="radio"/>	Heavy bleeding	<input type="radio"/>
Weight gain	<input type="radio"/>	Wheezing	<input type="radio"/>	Muscle cramps	<input type="radio"/>	Hot flashes	<input type="radio"/>
Weight loss	<input type="radio"/>	<b>GASTROINTESTINAL</b>		Muscle weakness	<input type="radio"/>	Irregular periods	<input type="radio"/>
<b>EYES</b>		Abdominal pain	<input type="radio"/>	<b>SKIN</b>		Nipple discharge <input type="radio"/>	
Blurry vision	<input type="radio"/>	Black tarry stools	<input type="radio"/>	Change in moles	<input type="radio"/>	Painful intercourse <input type="radio"/>	
Double vision	<input type="radio"/>	Bloating	<input type="radio"/>	Excessive dry skin	<input type="radio"/>	Painful periods <input type="radio"/>	
Dry Eyes	<input type="radio"/>	Bloody stools	<input type="radio"/>	Hair loss	<input type="radio"/>	Vaginal discharge <input type="radio"/>	
Eye discharge	<input type="radio"/>	Change in bowel habits	<input type="radio"/>	Hives	<input type="radio"/>	Vaginal itching <input type="radio"/>	
Eye pain	<input type="radio"/>	Constipation	<input type="radio"/>	Itching	<input type="radio"/>	Vaginal sores <input type="radio"/>	
Floater	<input type="radio"/>	Diarrhea	<input type="radio"/>	Nail changes	<input type="radio"/>		
Light sensitivity	<input type="radio"/>	Excessive gas	<input type="radio"/>	Rash	<input type="radio"/>		
Vision loss	<input type="radio"/>	Heartburn & indigestion	<input type="radio"/>	Skin cancer	<input type="radio"/>		
<b>EARS, NOSE &amp; THROAT</b>		Hemorrhoids	<input type="radio"/>	Sores non-healing	<input type="radio"/>		
Bleeding gums	<input type="radio"/>	Nausea	<input type="radio"/>	<b>NEUROLOGY</b>			
Earache	<input type="radio"/>	Swallowing difficulty	<input type="radio"/>	Concentration difficulty	<input type="radio"/>		
Ear discharge	<input type="radio"/>	Swallowing pain	<input type="radio"/>	Falling down	<input type="radio"/>		
Hearing loss	<input type="radio"/>	Vomiting	<input type="radio"/>	Headaches	<input type="radio"/>		
Hoarseness	<input type="radio"/>	Vomiting blood	<input type="radio"/>	Numbness or tingling	<input type="radio"/>		
Nasal congestion	<input type="radio"/>	<b>ENDOCRINE</b>		Paralysis	<input type="radio"/>		
Nosebleeds	<input type="radio"/>	Skin color has changed	<input type="radio"/>	Poor balance	<input type="radio"/>		
Ringing ears	<input type="radio"/>	Sweating., excessive	<input type="radio"/>	Seizures	<input type="radio"/>		
Seasonal allergies	<input type="radio"/>	Thirst, excessive	<input type="radio"/>	Tremors	<input type="radio"/>		
Sore throat	<input type="radio"/>	Unusual hair distribution	<input type="radio"/>	Weakness	<input type="radio"/>		
Vertigo	<input type="radio"/>						