Health Assessment Patient Questionnaire

Name: _____ Date: _____

Background Information

Age: _____ Birth date: _____ Preferred phone number: _____

E-mail: _____ Occupation: _____

Work hours: _____ Marital status: _____

Highest level of education: _____

Please list the people in your household and their relationships to you: _____

_____

General Health Information

Physician's name: _____ Physician's phone: _____

Physician's address: _____

Date of most recent physical exam: _____ Date of most recent blood tests: _____

How do you rate your health? _____ Poor _____ Fair _____ Good _____ Excellent

Height: _____ Weight: _____

Review of Systems (circle all that you currently have or are concerned about)

Respiratory

- ☐ Shortness of breath
- ☐ Coughing
- ☐ Asthma or wheezing
- ☐ Emphysema
- ☐ Snoring
- ☐ Daytime sleepiness
- ☐ Disturbed sleep
- ☐ Sleep apnea
- ☐ History of pneumonia, chronic bronchitis, or COPD

Cardiovascular

- ☐ High blood pressure
- ☐ Heart disease/heart attack
- ☐ Congestive heart failure
- ☐ Heart murmur
- ☐ Irregular heartbeat or palpitations
- ☐ Chest pain or discomfort
- ☐ Ankle or feet swelling
- ☐ Varicose veins
- ☐ Blood clots or clotting disorders

Gastrointestinal

Nausea/vomiting	Ulcer disease	Diarrhea
Abdominal/stomach pain	Rectal bleeding or blood in stools	Gallbladder disease/gallstones
Heartburn/acid reflux	Hemorrhoids	Celiac disease
Belching/burping	Constipation	Hernia

Genitourinary

Difficulty urinating	Inability to empty bladder fully	Sexual problems
Urinary incontinence (leaking urine)	Recurrent urinary tract infections (UTIs)	Abnormal menstrual periods
	Infertility	Enlarged prostate

Musculoskeletal

Aching muscles or joints	Lower back pain/disc problems	Arthritis

Endocrine

Diabetes mellitus	Thyroid disease	High triglycerides
High cholesterol	Gout	

Skin and Hair

Skin sores or infections (boils, ulcers, skin fold irritations)	Chronic rashes or dermatitis or eczema	Excessive facial/ body hair (women only)
Bruises easily		

Other

Low energy level	Obsessive-compulsive disorder (OCD)	Binge eating
Depression		Bulimia
Bipolar disorder	Psychological or psychiatric care	Anorexia
Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD)	History of child abuse, rape, or molestation	Anemia
		Headaches or migraines
Anxiety disorder or panic attacks	History of being subjected to any physical or verbal abuse	

Cancer (list type): _____

Other serious medical conditions (list types): _____

Do you have a family history of any of the following? (Circle all that apply)

High blood pressure, high blood cholesterol, diabetes, thyroid disease, obesity, heart disease, cancer, other (list):

_____

List the types of surgeries you have had: _____

_____

How often do you use tobacco? _____ How often do you drink alcohol?_____

How many hours of sleep do you average per night? _____ Is your sleep restful? Yes No

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life? _____

_____

Please list any religious practices that affect your heath care or diet:

_____

List all prescription and over-the-counter medications that you currently take (include the dosages):

_____

_____

_____

List all vitamins, minerals, supplements, and herbs that you take:

_____

_____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?

1 2 3 4 5

What makes it hard for you to lose weight and keep it off? _____

_____

_____

Nutrition Information

What one or two things would you like to change about your diet? _____

_____

In the following chart, describe when and what you usually eat in a typical day. (Write "None" if you do not eat that meal or snack.)

Meal	Time	Foods Eaten/Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Physical Activity Information

What is the most physically active thing you do in an average day? _____

_____

What, if any, regular exercises do you do? How often and for how long do you participate? _____

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons.

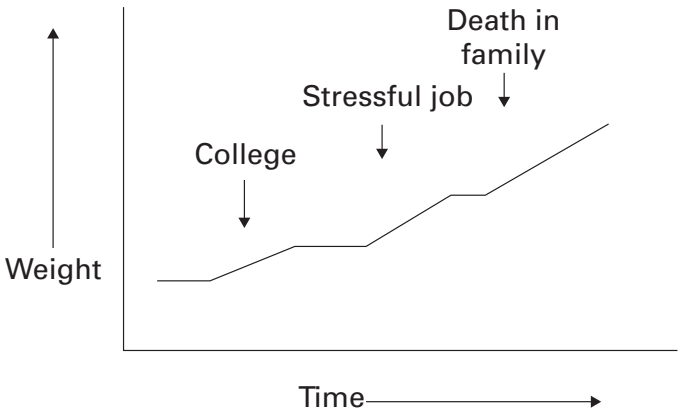
_____

_____

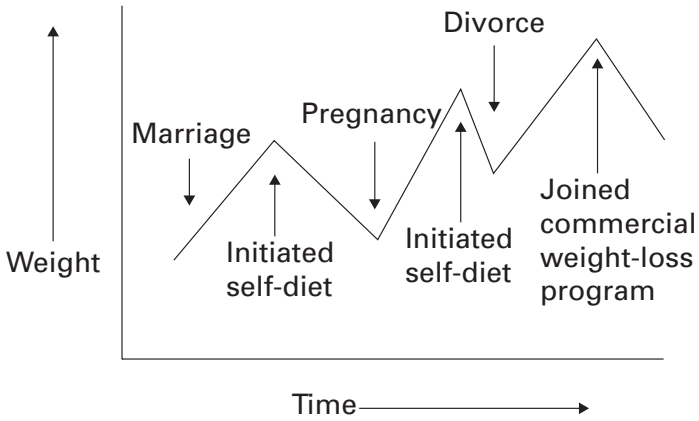
Weight History Graph

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

Progressive (or Ratcheting) Weight Gain



Weight Cycling or "Yo-Yo" Weight Gain



Please draw a graph of your weight gain. Mark *life events* and *diet attempts* that have contributed to your current weight.