SUBSEQUENT HEALTH QUESTIONNAIRE

Patient Name: _____

Patient DOB: _____

Physician: _____

Please complete this packet to the best of your ability. All questions contained in this questionnaire are strictly confidential and will become part of your medical record. For additional information, write or attach on back. If you come across any highly sensitive issues that you find difficult to write about but you'd still like to discuss, just indicate the issue with an asterisk (*) and we will talk about it during your examination.

Name of Doctor: _____ Today's Date: _____

REVIEW OF BODY SYSTEMS

If you've experienced any of the below, please indicate (with an X) and describe any symptoms that you are currently experiencing or that are of concern to you.

GENERAL

☐ Fevers ☐ Fatigue ☐ Weakness ☐ Change in Appetite ☐ Change in Weight
☐ Cold or Heat Intolerance ☐ Abnormal Sweating ☐ Flushing ☐ Chronic Pain

HEAD/EYES

☐ Headaches ☐ Dizzy Spells ☐ Faintness ☐ Seizures ☐ Loss of Consciousness
☐ Change in Vision ☐ Visual Disturbances

EARS

☐ Straining to Hear ☐ Missing Words ☐ Change in Hearing ☐ Noise in your Ears ☐ Ear Pain

NOSE

☐ Nasal Congestion ☐ Obstruction ☐ Discharge ☐ Change in Smell

THROAT

☐ Hoarseness ☐ Swollen Glands ☐ Persistent Sore Throat ☐ Neck Pain
☐ Gum or Dental Disease ☐ Floss Regularly ☐ Do Not Floss Regularly ☐ TMJ

BREASTS

☐ Pain ☐ Abnormal Lumps ☐ Skin Changes ☐ Nipple Discharge

RESPIRATORY

☐ Cough ☐ Shortness of Breath ☐ Wheezing ☐ Change in Sputum

CARDIOVASCULAR

☐ Chest Pains ☐ Palpitations ☐ Irregular Heart Beats ☐ Swollen Feet or Ankles
☐ Varicose Veins ☐ Calf or Leg Pains with Walking ☐ Hypertension (year of onset: _____)

GASTROESOPHAGEAL

☐ Nausea ☐ Vomiting ☐ Difficulty Swallowing ☐ Indigestion ☐ "Heartburn"
☐ Abdominal Pain ☐ Bloating ☐ Burping ☐ Gas ☐ Symptoms of Reflux

INTESTINAL

☐ Lower Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Excessive Flatus ☐ Hemorrhoids
☐ Rectal Pain ☐ Rectal Bleeding ☐ Changes in shape, color, frequency, consistency of bowel Movements

URINARY SYSTEM

☐ Increased Urinary Frequency ☐ Change in Urinary Stream ☐ Intermittent Stream
☐ Pain or Burning with Urination ☐ Getting up at Night to Urinate (No. of times: ____)
☐ Loss of Urine with coughing, sneezing, or effort ☐ History of Herpes or STDs: _____

MUSCULOSKELETAL

☐ Arthritis-Joint Pains ☐ Neck or Back Pain ☐ Muscle Pain or Weakness ☐ Tendonitis ☐ Bursitis ☐ Gout
☐ Foot Problems ☐ Change in Posture ☐ Disc Disease Disorder of Nerves or Muscles

SKIN, HAIR, NAILS

☐ Rashes ☐ Itching ☐ Psoriasis ☐ Seborrhea ☐ Acne ☐ Dry or Oily Skin
☐ Changes in Quality of Hair ☐ Excessive Hair Growth or Hair Loss ☐ Skin Cancers
☐ Persistent Sores ☐ Abnormal Pigmentation ☐ Changes in Nails

NEUROLOGICAL

☐ Changes in Memory ☐ Thinking ☐ Concentration or Speech ☐ Tremors
☐ Difficulties with Movement of Extremities ☐ Change in Balance or Gait ☐ Disorders of Sensation

HEMATOLOGIC

☐ Anemia ☐ Bruising ☐ Swollen Glands

FOR WOMEN
Age when Menses Began_____ Age at Menopause_____
☐ Painful Menstruation ☐ Heavier or Lighter Periods ☐ Irregular Periods ☐ Vaginal Discharge
☐ Vaginal Dryness or Irritation
Method(s) of Birth Control_____
☐ # of Pregnancies (total)_____ ☐ # of Miscarriages _____ ☐ # of Abortions _____
☐ Presently Pregnant or Breastfeeding ☐ Possibly Pregnant ☐ Change in Libido (sexual interest)
☐ Any issues about sexual fulfillment or sexual activity with regard to self or partner?
If yes, please explain:
Have you taken or do you take hormone replacement therapy? ☐ Yes ☐ No
☐ Early loss of ovarian function ☐ Hyperthyroidism ☐ Chronic diarrhea or intestinal malabsorption syndrome
☐ Have had an eating disorder such as anorexia or bulimia ☐ Low calcium intake ☐ Little or no exposure to sun
☐ High caffeine intake (2-3 cups/day) ☐ Perform physical activity excessively (causing missed periods)
☐ History of inflammatory bowel disease ☐ Obesity ☐ History of colorectal cancer or polyps
☐ Heavy alcohol use ☐ Inactive lifestyle

FOR MEN
☐ Changes in Urinary Stream ☐ Changes in Libido (sexual interest)
Method(s) of Birth Control: _____
Any issues concerning… (check all that apply):
☐ Premature Ejaculation
☐ Erectile Dysfunction
☐ Sexual Activity, or Fulfillment with Regard to Self or Partner
If yes, please explain: _____

NUTRITION SURVEY

Please check off and elaborate as necessary.

How would you rate your diet in general?

☐ Very Healthy ☐ Healthy ☐ Moderately Healthy ☐ Unhealthy ☐ Very Unhealthy

Comments: _____

_____

_____

Please describe the healthy aspects and unhealthy aspects of your diet.

_____

_____

_____

Which improvements would you like to achieve:

☐ Lower Salt
☐ Lower Fat, Cholesterol
☐ Less Oil, Butter, Mayo
☐ More Calcium
☐ More Calories, Fewer Calories
☐ More Whole Grains, More Fiber

☐ Less Candy/Chocolate
☐ Fewer Cakes/Pies/Cookies
☐ Less Bread, Potatoes, Rice, Pasta
☐ Less Fried Food
☐ Less Snack Food

☐ More Fruits and Vegetables
☐ More Carbohydrates

☐ Less "Junk" Food - Describe:
☐ Fewer Carbohydrates

☐ More Protein
☐ Less Fast Food
☐ Less Alcohol
☐ Fewer Pesticides

☐ Less Protein
☐ Less Meat, More Fish, More Soy
☐ Smaller Portion Size

On average, what is the total number of servings of fruits and vegetables that you have each day? _____

Which fruits and vegetables do you like? _____

Which fruits and vegetables do you not like? _____

Do any of these apply to you? (check all that apply)

☐ Milk intolerance ☐ hypoglycemia ☐ food allergies or other food intolerance

Would you like more information about nutrition? ☐ Yes ☐ No

What kind, how can we help you? (please explain) _____

_____

1-WEEK FOOD DIARY

Please complete the following food diary, logging your meals, snacks and drinks (including all non-alcoholic and alcoholic drinks consumed) for one week.

	BREAKFAST	LUNCH	DINNER	SNACKS	DRINKS
SUN					
MON					
TUES					
WED					
THURS					
FRI					
SAT					

EXERCISE HABITS

Please reply to questions and elaborate as needed.

How would you rate your present exercise habits?

□ Excellent □ Good □ Moderate □ Poor □ Very Poor

Please describe your present exercise habits (type and frequency):

List some of the benefits of exercise:

What have your exercise habits been like in the past?

Do you enjoy exercise? (Please comment)

What are some of your goals regarding exercise?

What has allowed you to reach your goals? What keeps you from 'reaching your goals?

Types of exercise you perform (please circle and comment below):

Swim Walk Jog Run Treadmill Roller Blade

Bicycle Basketball Baseball Sail Dance Golf

Tennis Tai Chi Judo Weight Lifting Handball Gardening

Gym Machines Aerobics Class House Cleaning Demanding physical labor at work

Other(s): _____

Comments:_____

_____

_____

_____

DEPRESSION REVIEW

INSTRUCTIONS: **The following is a list of symptoms that people frequently have. Put a check in the space to the right that best describes how much that symptom or problem has bothered you during the past week.**	0 - Never	1 – Somewhat	2 - Moderately	3 – A lot
Sadness: Have you been feeling sad or down in the dumps?				
Discouragement: Does the future look hopeless?				
Low self-esteem: Do you feel worthless or think of yourself as a failure?				
Inferiority: Do you feel inadequate or inferior to others?				
Guilt: Do you get self-critical and blame yourself for everything?				
Indecisiveness: Do you have trouble making up your mind about things?				
Irritability and frustration: Have you been feeling resentful and angry a good deal of the time?				
Loss of interest in life: Have you lost interest in your career, your hobbies, your family or your friends?				
Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
Poor self-image: Do you think you're looking old or unattractive?				
Appetite changes: Have you lost your appetite, or do you overeat or binge compulsively?				
Sleep changes: Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?				
Loss of libido: Have you lost your interest in sex?				
Hypochondriasis: Do you worry a great deal about your health?				
Suicidal impulses: Do you have thoughts that life is not worth living or think that you might be better off dead?				

Add up your total score for the 15 symptoms and record it here: _____

THE EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING (0 - 3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 & up	Very sleepy and should seek medical advice