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CloseCare™

COMPREHENSIVE HEALTH ASSESSMENT

Physical Examination - Information Update

Name____ Height___________ Weight_____________

Age____________ Ethnicity: Caucasian/Asian/ Hispanic/Black/ Jewish/ other __________________________

Nutrition

Restaurant food meals/ week________

High sugar containing beverages (soda) #/day_______

Describe the previous 24 hours of your diet including general serving size:

breakfast____

snack____

lunch____

snack____

dinner____

snack____

Serving of alcohol daily? (one 6 oz glass wine, one beer, one shot = 1 serving) ________________weekly_____________

Caffeinated beverages daily? Coffee___________ Tea ____________Soda ___________Other__-___________

Do you smoke? Yes/No_____ How many packs per day?_____ For how many years?______

Do you use cannabis in any form? Yes/No_______ Illicit drugs? Yes/No_______

Do you add salt to your food? Yes/ No________ Make an effort to select low salt containing foods? Yes/No_____

Supplements

Do you take:

Vit. D – Yes/No. Units daily = _______

Fish Oil- Yes/ No__________________

B12- Yes/ No_____________________

CoQ10- Yes/ No___________________

Others?__________________________

Over the Counter Medicines

Aspirin - Yes/ No If daily, mg dose=______

Ibuprofen/Alieve – Yes/ No________________

Zantac/ Pepcid/ Tums- Yes/ No_____________

Others?_________________________________

Exercise/ Fitness/ Falls

Walking or other ***moderate*** exercise >/= 3 hrs weekly? Yes/ No_________

30 min 5 days a week or more? Yes/ No________

(moderate level is considered a speed of 2 mile walk in an hour- brisk but able to carry on conversation at the same time)

Vigorous exercise >/= 75 minutes weekly? Yes/No_________

You consider yourself ***(circle):***

sedentary/ somewhat active/ moderately active/ very active/ serious athlete

Have you fallen w/in the past 12 months? Yes/ No ___How many times?_____

Circumstances?____

Women's Health History

Last menstrual period____________ frequency of cycles__________

Age of menopause?_______

Age of first menstrual period?______

Oral contraceptive ever? Yes/ No_____   For how many years?_____

Method of birth control?_________

Post menopausal hormone replacement ever? Yes/ No_______ For how many years?______

Sexual History

Currently sexually active? Yes/ No ____

sexual partners in past year? ______ If one, for how long? _______

Ever STD (sexually transmitted disease)? Yes/ No__________

Family History

Any new medical problems in your family? ____

Symptom Review

Over the past <u>6 months</u>, have you experienced any of the following symptoms (aside from the common cold)?

circle any that apply:

General: unintended weight loss/ weight gain/ fatigue

Head: headache/ runny nose/ stuffy nose/ sore throat/ difficulty with vision/ difficulty with hearing

Allergy: sneezing/ itchy watery eyes

Chest: cough/ shortness of breath/ wheezing/ chest pain / irregular heart beat

Gastrointestinal: heart burn/ constipation/ diarrhea/ hemorrhoids/ abdominal pain/ blood in stool/ change in bowel movements/ vomiting/ nervous stomach

Extremities/ Musculoskelital: ankle swelling/ joint pain/ back pain

Endocrine: low blood sugar/ high blood sugar/ hot flashes/ night sweats/ feeling excessively cold/ irregular menstrual periods/ painful periods

Urinary/Genital: pain with urination/ difficulty urinating/ vaginal discharge/ vaginal dryness/ blood in the urine/ difficulty w/sexual function

Mood: tearful/ irritable/ sad/ anxious/ nervous/ difficulty sleeping/ over sleeping/ poor motivation

Over the past <u>2 weeks</u>, how often have you been bothered by the following:

Little interest/pleasure in doing things? ***(circle)*** Not at all/Several days/More than ½ of days/Nearly daily

Feeling down, depressed, or hopeless? ***(circle)*** Not at all/Several days/More than ½ of days/Nearly daily

Last eye exam______________Last dental exam_______________