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CloseCare™

COMPREHENSIVE HEALTH ASSESSMENT

Questionnaire

Name_____ Height_____ Weight_____

Age_____ Ethnicity: Caucasian/Asian/ Hispanic/Black/ Jewish/ other _____

Weight at age 18_____ Weight at birth_____ Peak height as adult_____

Nutrition

(circle yes / no answers, add information on lines as needed)

Do you consume fish >/2 x weekly (not including shellfish)? Yes/ No_____ How often?_____

Red meat meals per day_____ per week_____

Shellfish (shrimp, lobster, scallops, crab) meals per day_____ per week_____

Do you consume fruit or vegetables 5 servings daily? (1/2 cup raw fruit or veg, ¾ cup fruit juice = 1 serving) Yes/ No_____

Whole grains 3 servings daily? (1/2 cup cereal, brown rice, whole grain pasta, popcorn, 1 slice bread = 1 serving) Yes/ No_____

Refined starches 3 servings daily? (1/2 cup cereal, rice, white pasta, 1 slice white bread = 1 serving) Yes/ No_____

Nuts 3 servings/ week? (1 TBS peanut butter, 1/8 cup nuts = 1 serving) Yes/ No_____

Butter, lard, red meat, cheese, whole milk 2 or more servings daily? Yes/ No_____

Vegetable shortening, baked goods (cookies, candies, cakes), fried fast foods most days? Yes/ No_____

Oil based salad dressing, liquid oil for cooking most days? Yes/ No_____

Green leafy vegetables (kale, lettuce, broccoli, cabbage, spinach, greens) daily? Yes/ No____

#dairy products servings daily? (serving = 1 cup milk or yogurt, 1.5 oz. cheese) _____

regular____2%____1%/lowfat____skim/nonfat_____

Tomato based foods 5 servings a week or more? (serving = ½ cup tomato sauce) Yes/ No_____

Fried foods /fast foods meals/ week_____

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 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

Are you happy w/ your current level of cardiovascular endurance? Yes/ No_____

Are you interested/ planning on increasing your physical fitness? Yes/No_____

If so, what do you plan to do (ie add weight training, add a sport, increase degree of vigor of your current activity)?_____

What would you like to improve in terms of physical fitness? _____

Do you see a trainer? Yes/ No_____ Physical therapist? Yes/ No_____

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

Circumstances?_____

Are you afraid of falling? Yes/ No_____

Exposures

Any exposures to tobacco? Smoker: Yes/ No____Chew: Yes/ No_____Cigar: Yes/ No____

Any significant exposures to 2nd hand smoke? Yes/No_____

Severe repeated sunburns as a child? Yes/ No_____

Drinking water from private well? Yes/ No_____. If yes it is tested for impurities such as arsenic regularly? Yes/No_____

Occupational Exposures

Ever work around production of aluminum/rubber/ aromatic amines for more than 5 years? Yes/ No___

Ever exposed to any of the following w/out adequate protection (ie respirator, protective clothing)?

Circle any exposures: Asbestos/Radon/Cadmium/Chromium/Beryllium/Aluminum/Silica/Sulfuric acid mist/ether and chloromethyl ether/Coke (oil refinement)/Mustard Gas

Ever involved w/ the following processes w/ out adequate protection? ***Circle any exposures:*** Arsenic smelting/Coal gasification/Iron or steel founding

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?_____

Developmental and Sexual History

Age of first sexual intercourse?_____

sexual partners in lifetime? _____

Currently sexually active? Yes/ No ____How many partners?____ If one, for how long? _____

Ever STD (sexually transmitted disease)? Yes/ No_____

Family History

Any family members with a history of bone fracture? Yes/ No_____(if yes, who)_____

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_____