REVOLUTIONARY HEALTH SERVICES

Wellness Evaluation Assessment: New Patient

Welcome to Revolutionary Health Services, where we empower our patients to live well!

This initial assessment will help us provide you with a one-of-a-kind healthcare experience.

_____ _____/_____/_____

Signature Date

Date Completed:_____/_____/_____

ABOUT YOU

What is your name? _____

What is your date of birth? _____/_____/_____

What is your gender? _____

What are your short-term goals for your health?

_____

_____

_____

Do you have any particular health concerns that you wish to discuss?

_____

_____

_____

What is your goal of this Wellness Evaluation?

☐ *Get out as soon as possible*. Give me a punch list of what I need to do without any explanation.

☐ *Be efficient.* Only discuss in more detail issues that I request, or that you feel are critically important. I'll get the rest of the information from my Wellness Plan.

☐ *I want to learn.* Expand on any issue you feel is necessary.

☐ *Other:* _____

About Your Medical History

Have you ever been diagnosed with any of the following:
Please check all that apply to you.

Cardiovascular
- ☐Cardiac Arrhythmia
- ☐Coronary Disease/Heart Attack
- ☐High Blood pressure
- ☐Peripheral Vascular Disease
- ☐Valvular Heart Disease
- ☐Other Heart Condition

_____

Ear, Nose and Throat (ENT)
- ☐Allergies
- ☐Deviated Septum
- ☐Frequent Sinusitis
- ☐Hearing Loss
- ☐Nasal Polyps
- ☐TMJ Syndrome
- ☐Vertigo
- ☐Other Ear/Nose/Throat Condition

_____

Musculoskeletal
- ☐Carpal Tunnel Syndrome
- ☐Chronic Back Pain
- ☐Fibromyalgia
- ☐Gout
- ☐Hernia
- ☐Osteoarthritis
- ☐Rheumatoid Arthritis
- ☐Sciatica
- ☐Scoliosis
- ☐Other Musculoskeletal Condition

_____

Pulmonary
- ☐Asthma
- ☐Emphysema/Chronic Bronchitis
- ☐Sleep Apnea
- ☐Other Lung Condition

_____

Endocrine
- ☐Diabetes/Prediabetes/Metabolic Syndrome
- ☐High Cholesterol
- ☐Hypothyroidism/Hyperthyroidism/Goiter
- ☐Other Endocrine Condition

_____

Gastrointestinal
- ☐Colon Polyps
- ☐Constipation
- ☐Gallstones
- ☐GERD/Reflux/Acid Indigestion/Hiatal Hernia
- ☐Hepatitis (Type _____, if known)
- ☐Irritable Bowel Syndrome
- ☐Peptic Ulcers (duodenal/gastric)
- ☐Ulcerative Colitis/Crohns
- ☐Other GI Condition

_____

Opthomology
- ☐Color Blind
- ☐Glaucoma/Cataract
- ☐Other Eye Condition

_____

Neurology
- ☐Migraine Headaches
- ☐Seizures
- ☐Stroke
- ☐Other Neurological Conditions

_____

Renal
- ☐Frequent UTIs
- ☐Kidney Stones
- ☐Overactive Bladder
- ☐Urinary Incontinence
- ☐Other Urinary Condition

_____

About Your Medical History

Psychiatric

☐Anxiety
☐Bipolar Disorder
☐Depression
☐Eating Disorder
☐Obsessive-Compulsive Disorder
☐Psychosis
☐Schizophrenia
☐Other Psychiatric Condition

_____

Skin

☐Actinic Keratosis
☐Basal Cell Cancer
☐Eczema
☐Hair Condition
☐Melanoma
☐Psoriasis
☐Squamous Cell Cancer
☐Varicose Veins
☐Other Skin Condition

_____

Other

☐Anemia
☐Bleeding Disorder
☐Clots in Legs/Lungs (DVT/Pulmonary Embolism)
☐Other Blood Condition

_____

☐Cancer
☐Chicken Pox
☐HIV/AIDS
☐Sexually Transmitted Disease
☐Tuberculosis
☐Other Infectious Disease

_____

☐Autoimmune Condition
☐Other Medical Condition

_____

Men

☐Elevated PSA
☐Epididymitis
☐Prostatitis
☐Other Genital Condition

_____

Women

☐Abnormal PAP Smear
☐Breast Condition
☐Ovarian Cysts
☐Other Gynecologic Condition _____
Number of Pregnancies: _____
Number of Deliveries: _____

Please list all **HOSPITALIZATIONS** and **SURGERIES** you have had and give the approximate **DATE** of each.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

About Your Medical History

Allergies:

Do you have any allergies to medications, foods or other substances? Please list them and the type of reaction below:

Allergen	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Prescription Medications:

Please list all medications you are currently taking (include dosage).

Example: Zyrtec 5mg/day

Medication & Dosage	Medication & Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Supplements:

Please list all supplements you are currently taking (including dosage).

Vitamin D	_____mg	Magnesium	_____mg
Fish Oil	_____mg	Co Enzyme Q10	_____mg
Aspirin	_____mg	Folic Acid	_____mg

Other Supplements:

_____	_____mg	_____	_____mg
_____	_____mg	_____	_____mg
_____	_____mg	_____	_____mg

About Your Family History

Is your mother alive? ☐ YES ☐ NO

If no, at what age did she pass? _____ Cause:_____

Is your father alive? ☐ YES ☐ NO

If no, at what age did he pass?_____ Cause:_____

Number of brothers? _____ alive: _____ deceased:_____

Number of sisters? _____ alive:_____ deceased:_____

Do you have any children? ☐YES ☐ NO If YES, how many children? _____

Please check any medical problems experienced by your family members:

Family Member	Cancer	Type of Cancer	Diabetes	Heart Disease	Age at time of diagnosis	Other chronic medical issue
Mother						
Father						
Brothers						
Sisters						
Children						
Grandparents						

About your Health Maintenance

Your Medical Health:

Which of the following screening and preventive services have you had?

Please check all that apply to you.

☐ Dental Exam Month/Year:____/_____ Name of Dentist: _____

☐ Mammogram Month/Year: ____/____ Name of OB/Gyn:_____

☐ Vision Exam Month/Year:___/____ Name of Doctor:_____

☐ Gynecologic Internal Exam Month/Year:_____/_____

☐ Rectal Exam/Prostate Exam Month/Year:_____/_____

☐ Colonoscopy or stool check for blood Month/Year:_____/_____

☐ Diabetic foot/eye exam Month/Year:_____/_____

☐ Ultrasound screening for Abdominal Aortic Aneurysm Year:_____

☐ Flu Vaccination Year:_____

☐ Shingles Vaccine Year:_____

☐ Hepatitis A Year:_____

☐ Hepatitis B Year:_____

☐ Tdap Year:_____

☐ Td Year:_____

☐ HPV Year:_____

☐ Meningococcal Year:_____

☐ Prevnar (PCV 13) Year:_____

☐ Pneumovax (PSV23) Year:_____

About Your Lifestyle Habits

Drinking Habits:

Do you drink alcohol? Please check only one answer.

☐ Yes. How many glasses of alcohol do you consume weekly? _____
(A drink is 5 oz of wine or 1.5oz of spirits or 12oz of beer)

☐ No

☐ Only very occasionally, less than one drink per week

Tobacco Usage:

Do you smoke or use chewing tobacco?

☐ Yes, I currently smoke.

☐ No, I gave up tobacco less than 10 years ago.

☐ No, I gave up tobacco more than 10 years ago.

☐ No, I have never smoked or chewed tobacco (if you select this answer, please skip to the next section)

☐ No, but I live with someone that smokes.
(if you select this answer, please skip to the next section)

Which of the following **tobacco products** do you/did you use?

Please write how much you use and how long you have used these products.

	In a single day, how many?	How many years?
☐**Cigarettes**	_____	_____
☐**Cigars**	_____	_____
☐**Pipes**	_____	_____
☐**Chewing Tobacco**	_____	_____

About Your Lifestyle Habits

Exercise and Physical Activity:

In a typical 7-day week. How much of the following exercise do you get? Please write the number of days of exercise and the average time (in minutes) spent exercising.

Vigorous Physical Activity

Example: heavy lifting, digging, aerobics or fast cycling

Number of Days:_____ Average time each day (minutes): _____

Moderate Physical Activity

Example: carrying light loads, cycling at regular pace, tennis

Number of Days:_____ Average time each day (minutes): _____

Walking for at least 10 minutes

Example: walking at home, work or for exercise or leisure

Number of Days:_____ Average time each day (minutes): _____

Resistance Training

Example: free weights, body weight exercises, weight machines

Number of Days:_____ Average time each day (minutes): _____

About Your Lifestyle Habits

Your Sleep Habits:

How many hours of sleep do you get on a typical weekday night and a typical weekend or non-working night?

Write down the hours and minutes of sleep.

Weekday/Work-Night

Hours _____

Minutes _____

Weekend/ Non-work Night

Hours _____

Minutes _____

	Yes	No
Do you feel rested upon waking?	☐	☐
Do you have difficulty falling asleep at night?	☐	☐
Do you have difficulty staying asleep at night?	☐	☐
Do you snore?	☐	☐
Do you feel unusually tired through the day?	☐	☐
Do you ever wake yourself choking/gasping?	☐	☐
Have you ever been told you stop breathing or choke/gasp while sleeping?	☐	☐

About Your Lifestyle Habits

Your Sleep Habits:

Please complete the following chart thinking about your usual way of life in recent times. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

	Would never doze off	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	Your score
Sitting and reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting, inactive in a public place (e.g. theater or meeting)	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after a lunch with alcohol	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	
YOUR TOTAL SCORE: _____					

Adapted from the Epworth Sleepiness Scale

About Your Lifestyle Habits

Your Oral Health:

	Yes	No
Have you ever been told you had periodontal disease?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐
Do you use mouthwash? If yes, which brand? _____	☐	☐
Do you have any loose teeth, dental pain or sensitivity?	☐	☐
Do you floss? If yes, how often? _____ times per week	☐	☐
Do you have any unusual growths in your mouth?	☐	☐
Have you ever been diagnosed with Human Papillomavirus (HPV) or genital warts?	☐	☐

Please check off the type of toothbrush you currently use.

☐ Traditional

☐ Oral B (electric toothbrush)

☐ Sonicare

☐ Other: _____

About Your Lifestyle Habits

Your Occupation:

Which of the following describes your current employment status?

☐Employed (Full-time) Occupation: _____
☐Employed (Part-time) Occupation: _____
☐Not working for pay (Student)
☐Not working for pay (Stay-at-home parent)
☐Not working for pay (Full-time career)
☐Unemployed
☐Retired Former Occupation: _____
☐Other

About Your Lifestyle Habits

Your Safety:

When driving or riding in a car, do you wear a seatbelt?
Please check one answer only.

☐ Never
☐ Sometimes
☐ Most times
☐ Always

Do you feel or have you ever felt unsafe or threatened in your home environment or relationships?
Please check only one answer.

☐ Yes
☐ No (*if you selected this answer, please skip to the next section*.)

If you said that you have at some time felt unsafe or threatened:
Please check one answer for each question.

Have you ever been in a relationship when you have been physically harmed or threatened with physical violence? ☐ YES ☐ NO

Are your friends or family aware of this situation? ☐ YES ☐ NO

Do you have a safe place to go and the resources you need in an emergency?
☐ YES ☐ NO

Do you feel safe in all of your current relationships? ☐ YES ☐ NO

About Your Lifestyle Habits

Your Stress/Emotional Health:

How many people live at home with you? _____

Thinking about your life, on average how stressed and under pressure do you feel? Think about all areas of your life: work, home and family.

On a scale of 1 -10, please check the number that most closely represents your answer.

1☐ 2☐ 3☐ 4 ☐ 5 ☐ 6 ☐ 7☐ 8☐ 9 ☐ 10☐

Not stressed at all — Extremely stressed

How are you coping with stress and pressure in your life?

Please check only one answer.

☐Not coping well

☐Struggling a bit

☐Coping OK

☐Coping well

☐Coping really well

What are your coping mechanisms?

☐Therapy

☐Meditation

☐Yoga

☐Exercise

☐Spiritual guidance

☐Other:_____

About Your Lifestyle Habits

Your Stress/Emotional Health:

Thinking back over the past 3 months, how often have you felt anxious or nervous for no real reason?

On a check of 1 -10, please circle the number that most closely represents your answer.

1☐ 2☐ 3☐ 4☐ 5 ☐ 6☐ 7☐ 8☐ 9☐ 10☐

Not at all All the time

Thinking back over the past 3 months, how often have you felt sad, miserable or depressed?

On a scale of 1 -10, please check the number that most closely represents your answer.

1☐ 2☐ 3☐ 4☐ 5☐ 6 ☐ 7 ☐ 8☐ 9☐ 10☐

Not at all All the time

How would you describe the support you are able to get from other people during times of stress? Think about people who are close to you and you know will help and listen when times are tough.

On a scale of 1 -10, please check the number that most closely represents your answer.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Not at all All the time

About Your Lifestyle Habits

Your Overall Health & Happiness:

In general, how would you rate your overall health?

☐Excellent
☐Very good
☐Good
☐Fair
☐Poor

In general, how would you rate your satisfaction and happiness in life?

☐Excellent
☐Good
☐OK
☐Not good
☐Terrible

How important is it to make changes to your lifestyle to improve your health?

Place an "X" along the line that best indicates your answer.

Very important Not important

How ready are you to start making these changes?

Place an "X" along the line that best indicates your answer.

I'm ready Not ready

How confident are you that you'll succeed?

Place an "X" along the line that best indicates your answer.

Very confident Not confident

About Your Lifestyle Habits (Women)

Your Sexual Health:

Are you sexually active? ☐ YES ☐ NO

If using contraception, which method are you using? _____

Please answer the following questions. Thinking about the past 6 months……

Last menstrual period Month/Year: _____/_____

Do you experience irregular or heavy periods? ☐YES ☐ NO

Do you experience painful periods or pelvic pain? ☐YES ☐ NO

Do you perform monthly self-breast exams? ☐YES ☐ NO

Please check only one answer for each question below.

Are you satisfied with your level of sexual desire or interest?

☐Always ☐Most times ☐Sometimes ☐Never

Are you satisfied with your level of lubrication during sexual activity or intercourse?

☐Always ☐Most times ☐Sometimes ☐Never

Do you experience discomfort or pain during sexual activity or intercourse?

☐Always ☐Most times ☐Sometimes ☐Never