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 (MEN)

Your Sexual Health:

Are you sexually active? ☐ YES ☐ NO

If using contraception, which method are you using? ________________________

Please answer the following questions thinking back over the past 6 months…

How do you rate your confidence that you can get and keep and erection?

☐Very low ☐ Low ☐ Moderate ☐High ☐ Very high

During sexual intercourse, how often were you able to maintain your erection after you have penetrated (entered) your partner?

☐ Almost never/never
☐ A few times
☐ Sometimes
☐ Most times
☐ Almost Always/always

Are you satisfied with you sex life? Please check only one answer.

☐ Never
☐ Sometimes
☐ Most times
☐ Always
☐ I prefer not to answer this question

About Your Lifestyle Habits (MEN)

International Prostate Symptom Score (I-PSS)

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
Incomplete emptying: Over the past month, how often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
Frequency: Over the past month, how often have you have to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency: Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
Weak Stream: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining: Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
PLEASE ENTER YOUR TOTAL SCORE:							

Nocturia: Over the past month, **how many times did you most typically get up** to urinate from the time you went to bed at night until the time you got up in the morning? ________________

Quality of Life due to urinary symptoms:

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

<u>Place an "X" along the line</u> that best represents your answer.

____

Delighted | neither satisfied/ or dissatisfied | Terrible