REVOLUTIONARY HEALTH SERVICES

Wellness Assessment: Current Patient

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

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

_____ _____/_____/_____
Signature Date

Date Completed:_____/_____/_____

About Your Medical History

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 Lifestyle Habits

Drinking Habits:

How many of the following beverage do you usually consume in a typical day?

Coffee _____ Tea _____ Water _____

Diet Soda _____ Soda _____ Juice _____

Energy Drink _____ Milk _____ Milk Shake _____

Hot Chocolate _____

Do you drink alcohol? Please check only one answer.

☐ Yes
☐ No (if you select this answer- please skip to the next section)
☐ Only very occasionally, less than one drink per week (if you select this answer- please skip to the next section)

Add up the **total number of alcoholic drinks** you consume in an average week.
Please write number of each type of drink you consume on the lines below.

Beer (12oz) _____ White Wine (5oz) _____

Red Wine (5oz) _____ Malt Liquor (8oz) _____

Shot of Spirits (1.5oz) _____ Wine Cooler (12oz) _____

Mixed Drinks (1.5oz) _____ Cocktails (1.5oz) _____

About Your Lifestyle Habits

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): _____

Stretching

Please circle your answer.

Before Exercise ☐ YES ☐ NO

After Exercise ☐ YES ☐ NO

Yoga ☐ YES ☐ NO

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:

Have you ever been told you had periodontal disease? ☐YES ☐ NO

Do your gums bleed when you brush or floss? ☐ YES ☐NO

Do you use mouthwash? ☐ YES ☐ NO

Brand:_____

Do you have any loose teeth, dental pain or sensitivity? ☐ YES ☐ NO

Do you floss? ☐ YES ☐ NO How often? _____ times per week

Do you have any unusual growths in your mouth? ☐ YES ☐ NO

Have you ever been diagnosed with Human Papillomavirus (HPV) or genital warts? ☐ YES ☐ NO

Please check off the type of toothbrush you currently use.

☐ Traditional
☐ Oral B (electric toothbrush)
☐ Sonicare
☐ Other: _____

About Your Lifestyle Habits (MEN)

Your Sexual Health:

Are you sexually active? ☐ YES ☐ NO

If using contraception, which method are you using? _____

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

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?

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

_____

Delighted | neither satisfied/ or dissatisfied | Terrible

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 circle 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 scale 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 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

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 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

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