REVOLUTIONARY HEALTH SERVICES

PATIENT NAME: ________________________________ **DOB:**_________________

ADULT HEALTH ASSESSMENT SHEET

List your short-term goals for your health.

From a health perspective, how do you envision your life when you are "old".

Do you have any health concerns you would like to discuss at this time?

PERSONAL MEDICAL HISTORY

Please check all that apply. Details can be discussed at your visit.

ENT

☐ Hearing Loss

☐ Vertigo

☐ Deviated Septum

☐ Frequent Sinusitis

☐ Allergies

☐ Nasal Polyps

☐ TMJ Syndrome

☐ Other Ear/Nose/Throat Condition

Pulmonary

☐ Emphysema/Chronic Bronchitis

☐ Sleep Apnea

☐ Asthma

☐ Other Lung Condition

Renal

☐ Kidney Stones

☐ Urinary Incontinence

☐ Overactive Bladder

☐ Frequent UTIs

☐ Other Urinary Condition

Neurology

☐ Stroke

☐ Seizures

Ophthalmology

☐ Color Blind

☐ Glaucoma/Cataract

☐ Other Eye Condition

Cardiovascular

☐ High Blood Pressure

☐ Coronary Disease/Heart Attack

☐ Valvular Heart Disease

☐ Cardiac Arrhythmia

☐ Peripheral Vascular Disease

☐ Other Heart Condition

GI

☐ Peptic Ulcers (duodenal/gastric)

☐ GERD/Reflux/Acid Indigestion/Hiatal Hernia

☐ Colon Polyps

☐ Irritable Bowel Syndrome

☐ Hepatitis (type if known)

☐ Gallstones

☐ Ulcerative Colitis/Crohns

☐ Other GI Condition

Endocrine

☐Diabetes/Prediabetes/Metabolic Syndrome

☐ High Cholesterol

☐ Migraine Headaches

☐ Other Neurologic Condition

Musculoskeletal

☐ Carpal Tunnel Syndrome

☐ Fibromyalgia

☐ Hernia

☐ Osteoarthritis

☐ Rheumatoid Arthritis

☐ Scoliosis

☐ Sciatica

☐ Chronic Back Pain

☐ Gout

☐ Other Musculoskeletal Condition

Psychiatric

☐ Depression

☐ Anxiety

☐ Bipolar Disorder

☐ Obsessive-Compulsive Disorder

☐ Eating Disorder

☐ Schizophrenia

☐ Psychosis

☐ Other Psychiatric Condition

Men

☐ Prostatitis

☐ Epididymitis

☐ Elevated PSA

☒ Other Genital Condition

☐ Hypothyroidism/Hyperthyroidism/Goiter

☐ Other Endocrine Condition

Skin

☐ Varicose Veins

☐ Psoriasis

☐ Eczema

☐ Hair Condition

☐ Actinic Keratosis

☐ Melanoma

☐ Basal Cell Cancer

☐ Squamous Cell Cancer

☐ Other Skin Condition

☐ Rosacea

Other

☐ Anemia

☐ Bleeding Disorder

☐ Clots in Legs/Lungs (DVT/Pulmonary Embolism)

☐Other Blood Condition

☐ Cancer

☐ HIV/AIDS

☐ Tuberculosis

☐ Sexually Transmitted Disease

☐ Chicken Pox

☐ Other Infectious Disease

☐ Autoimmune Condition

☐ Other Medical Condition

Please share any additional information about your Personal Medical History not listed above:

Please list all **HOSPITALIZATIONS and OPERATIONS** you have had and give the **approximate DATE** of each.
For Example: *Left Hip Replacement May 2010*

HOSPITALIZATION/OPERATION AND DATE	HOSPITALIZATION/OPERATION AND DATE

ALLERGIES
Do you have any allergies to medications, foods, or other substances? If yes, please list along with the reaction you have.
For example: *Penicillin – hives*

ALLERGEN AND REACTION	ALLERGEN AND REACTION

MEDICATIONS
Please list (or attach a list) all **PRESCRIPTION MEDICATIONS** including the **DOSES** that you are currently taking:
FOR EXAMPLE *Zyrtec 5mg/day*

MEDICATION & DOSAGE	MEDICATION & DOSAGE

Please list any **supplements** you currently take. For example: *Calcium 1000mg*

Vitamin D ______mg	Magnesium ______mg
Fish Oil ______mg	Co Enzyme Q10 ______mg
Aspirin ______mg	Folic Acid _______mg
Probiotic _______mg	_____________________ ________mg

_____________________	_______mg	____________________	________mg
______________________	_______mg	____________________	________mg

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:

Mother	Father	Brother (s)	Sister (s)	Children	Grandparent (s)
Heart Disease Age diagnosed ______	Heart Disease Age diagnosed ______	Heart Disease Age diagnosed ______	Heart Disease Age diagnosed _______	Heart Disease Age diagnosed ______	Heart Disease Age diagnosed _______
Diabetes Age diagnosed ______	Diabetes Age diagnosed _______	Diabetes Age diagnosed _______	Diabetes Age diagnosed _______	Diabetes Age diagnosed _______	Diabetes Age diagnosed _______
Dementia Age diagnosed ________	Dementia Age diagnosed _______	Dementia Age diagnosed _______	Dementia Age diagnosed _______	Dementia Age diagnosed _______	Dementia Age diagnosed ______
Cancer Type _______________ Age diagnosed _______	Cancer Type _______________ Age diagnosed ______	Cancer Type _______________ Age diagnosed _______	Cancer Type _______________ Age diagnosed _______	Cancer Type _______________ Age diagnosed _________	Cancer Type _______________ Age diagnosed _______
Other Chronic Medical Issue ______________	Other Chronic Medical Issue _______________	Other Chronic Medical Issue ________________	Other Chronic Medical Issue ______________	Other Chronic Medical Issue _______________	Other Chronic Medical Issue _____________

SOCIAL HISTORY

Do you use **tobacco** products? ☐ Yes ☐ No If yes, what type and how much? ______________________________

Have you **ever used tobacco** products: ☐ Yes ☐ No If yes, for how many years? ___________

When did you quit?_____________ Average packs per day ___________

Do you drink **alcohol**? ☐ Yes ☐ No If yes, how much per week? _______________________

Do you **exercise** regularly? ☐ Yes ☐ No If yes, please complete below:

	times/week - duration		times/week - duration
Aerobic	_______ - ________	Resistance	________ - ________
Other	________ - ________	Stretching	before/after exercise

Please describe your exercise routine.

Please describe your **approach to eating**. Include frequency, sizes, whether you focus on portion control, Low carbs, low fat, or if you simply have a *see* food diet (i.e. "I see it, I eat it")

How many people live with you now? ________

Present occupation?________________________Previous occupations? __________________________________

Please CHECK the **IMMUNIZATIONS** you have received and list approximate DATE when received:

Hepatitis A WHEN ___________

Hepatitis B WHEN ___________

Tetanus WHEN __________

Flu Shot WHEN ___________

Pneumococcal (PPSV23) WHEN ____________

Prevnar (PCV13) WHEN __________

Shingles WHEN _____________

Please list any other IMMUNIZATIONS you have received.

HEALTH MAINTENANCE HISTORY
Please check all that apply to you.

Dental Exam Month/Year:_____/_______ Name of Dentist: __________________________

Dermatology Exam Month/Year: _____/_____ Name of Dermatologist:___________________

Vision Exam Month/Year:____/_____ Name of Doctor:__________________________

Colonoscopy or stool check for blood Month/Year:_______/_________

Cardiovascular Testing Name of test:_________________________ Month/Year:________/_________

Ultrasound screening for Abdominal Aortic Aneurysm Year:___________

Bone density testing Year:______________

Last PSA (month/year) _________ Value:___________

Last rectal exam (month/year) _________

What other specialists do you see at least yearly?

SYMPTOM REVIEW

SLEEP

How much sleep do you average nightly? ____________________

How much sleep do you feel you need nightly? ____________________

If you sleep less than you feel you need, why?

Do you feel your sleep is restful? ☐ Usually ☐ Sometimes ☐ Occasionally ☐ Rarely

Do you snore? ☐ Yes ☐ No

Do you feel rested upon waking? ☐ Yes ☐ No

Do you feel unusually tired through the day? ☐ Yes ☐ No

Do you ever wake yourself choking/gasping? ☐ Yes ☐ No

Have you been told you stop breathing or choke/gasp while sleeping? ☐ Yes ☐ No

ORAL CARE

Did your dentist examine for oral cancer lesions at your last hygiene appointment? ☐ Yes ☐ No

Have you ever been told you had periodontal disease? ☐ Yes ☐ No

Do your gums ever bleed when you floss or brush? ☐ Yes ☐ No

Do you have tooth pain? ☐ Yes ☐ No

Do you have tooth sensitivity? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

When was your last dental hygiene appointment? __________________________________

Do you floss or use dental picks? ☐ Yes ☐ No If yes, how often? _______________________

What type of brush do you use? ☐ Oral B ☐ Sonicare other ___________________________

Do you use any mouth rinses? ☐ Yes ☐ No If yes, which one(s)? ____________________________

GASTROINTESTINAL HEALTH

Do you experience the following? Check all that apply.

☐ Indigestion ☐ Constipation ☐ Gas ☐ Abdominal pain ☐ Bloating ☐ Loose stools

Are these symptoms worsened by stress or travel? ☐ Yes ☐ No

METABOLIC HEALTH

Do you get lightheaded, irritable, or tiredness that is relieved by eating? ☐ Yes ☒ No

Do you sometimes get unusually tired after a meal? ☐ Yes ☐ No

Do you sometimes experience a “racing” or “skipped” heart beat? ☐ Yes ☐ No

BRAIN HEALTH

Please check all that apply to you.

Do you notice any of the following?

☐ Increasing difficulty remembering names.

☐ Brain fog or reduced mental clarity, especially later in the day

☐ Increased difficulty following complex conversations or movies

☐ Reduced thought processing speed

☐ Difficulty remembering or getting overwhelmed with to-do lists

☐ Mixing up words

☐ Decreasing vocabulary or word finding ability

☐ Difficulty or anxiety with finding your way driving

☐ Reduced mental boost from caffeine

☐ Decreasing ability to remember what you have read or heard, especially later in the day

SEXUAL HEALTH

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

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

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

When you had erections with sexual stimulation, <u>how often</u> were your erections hard enough for penetration (entering your partner)?

No sexual activity	Almost never or Never	A few times (much less than Half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

During sexual intercourse, <u>how often</u> were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt Intercourse	Almost never or never	A few times (much less than Half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

During sexual intercourse, <u>how difficult</u> was it to maintain your erection to completion of intercourse?

Did not attempt Intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

When you attempted sexual intercourse, <u>how often</u> was it satisfactory for you?

Did not attempt Intercourse	Almost never or never	A few times (much less than Half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

URINARY HEALTH

<u>International Prostate Symptom Score (I-PSS)</u>

	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	Yours Score
1. **Incomplete emptying** Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**	______
2. **Frequency** Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**	______
3. **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**	______

Question							
4. **Urgency** Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	______
5. **Weak stream** Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	______
6. **Straining** Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	______

	None	1 time	2 times	3 times	4 times	5 times or more	Yours Score
7. **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?	0	1	2	3	4	5	______

Total I-PSS Score __________

	Delighted	Pleased	Mostly Satisfied	Mixed equally Satisfied and Dissatisfied	Mostly Dissatisfied	Unhappy	Terrible
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?	0	1	2	3	4	5	6

The international Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms. Each question allows the patient to choose one of five answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic). Furthermore, the International Consensus Committee (ICC) recommends the use of only a single question to assess the quality of life. The answers to this question range from “delighted” to “terrible” or 0 to 6. Although this single question may or may not capture the global impact of BPH symptoms or quality of life, it may serve as a valuable starting point for a doctor-patient conversation. The ICC strongly recommends that all physicians who counsel patients suffering from symptoms of prostatism utilize these measures not only during the initial interview but also during and after treatment in order to monitor treatment response.

The ICC under the patronage of the World Health Organization (WHO) has agreed to use the symptom index for benign prostatic hyperplasia (BPH), which has been developed by the American Urological Association (AUA) Measurement Committee, as the official worldwide symptoms assessment tool for patients suffering from prostatism.

Completed by: ______________________________ Date: ______________

Reviewed by: ______________________________ Date: ______________