HEALTH QUESTIONNAIRE

Patient Name: ____

Date of Birth: ____

Physician: ____

CONCIERGE PHYSICAL

DATE: ______________________________

TIME: ______________________________

Rev 12.13.21/ls

REVIEW OF BODY SYSTEMS If you've experienced any of the below symptoms, please indicate (with an X) and describe any symptoms that you are currently experiencing or that are of concern to you.
GENERAL ☐ Fevers ☐ Fatigue ☐ Weakness ☐ Change in Appetite ☐ Change in Weight ☐ Cold or Heat Intolerance ☐ Abnormal Sweating ☐ Flushing ☐ Chronic Pain
HEAD/EYES ☐ Headaches ☐ Dizzy Spells ☐ Faintness ☐ Seizures ☐ Loss of Consciousness ☐ Change in Vision ☐ Visual Disturbances
EARS ☐ Straining to Hear ☐ Missing Words ☐ Change in Hearing ☐ Noise in Your Ears ☐ Ear Pain
NOSE ☐ Nasal Congestion ☐ Obstruction ☐ Discharge ☐ Change in Smell
THROAT ☐ Hoarseness ☐ Swollen Glands ☐ Persistent Sore Throat ☐ Neck Pain ☐ Gum or Dental Disease ☐ TMJ
BREASTS ☐ Pain ☐ Abnormal Lumps ☐ Skin Changes ☐ Nipple Discharge
RESPIRATORY ☐ Cough ☐ Shortness of Breath ☐ Wheezing ☐ Sputum
CARDIOVASCULAR ☐ Chest Pains ☐ Palpitations ☐ Irregular Heart Beats Swollen Feet or Ankles ☐ Varicose Veins ☐ Calf or Leg Pains with Walking
GASTROESOPHAGEAL ☐ Nausea ☐ Vomiting ☐ Difficulty Swallowing ☐ Indigestion ☐ "Heartburn" ☐ Abdominal Pain ☐ Bloating ☐ Burping ☐ Gas ☐ Symptoms of Reflux
INTESTINAL ☐ Lower Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Excessive Flatus ☐ Hemorrhoids ☐ Rectal Pain ☐ Rectal Bleeding ☐ Changes in Shape, Color, Frequency, Consistency of Bowel Movements
URINARY SYSTEM ☐ Increased Urinary Frequency ☐ Change in Urinary Stream ☐ Intermittent Stream ☐ Pain or Burning with Urination ☐ Getting up at Night to Urinate (No. of Times ______) ☐ Loss of Urine with Coughing, Sneezing, or Effort ☐ History of Herpes or STDs: ______________________
MUSCULOSKELETAL ☐ Arthritis-Joint Pains ☐ Neck or Back Pain ☐ Muscle Pain or Weakness ☐ Tendonitis ☐ Bursitis ☐ Gout ☐ Foot Problems ☐ Change in Posture
SKIN, HAIR, NAILS ☐ Rashes ☐ Itching ☐ Psoriasis ☐ Seborrhea ☐ Acne ☐ Dry or Oily Skin ☐ Changes in Quality of Hair ☐ Excessive Hair Growth/Loss ☐ Skin Lumps ☐ Persistent Sores ☐ Abnormal Pigmentation ☐ Changes in Nails
NEUROLOGICAL ☐ Changes in Memory ☐ Thinking ☐ Concentration or Speech ☐ Tremors ☐ Difficulties with Movement ☐ Change in Balance or Gait ☐ Disorders of Sensation
HEMATOLOGIC ☐ Anemia ☐ Bruising ☐ Swollen Glands

FOR WOMEN
Age when Menses Began _____ Age of Menopause _____
◻ Painful Menstruation ◻ Heavier or Lighter Periods ◻ Irregular Periods ◻ Vaginal Discharge
◻ Vaginal Dryness or Irritation
Methods of Birth Control: ____
# of Pregnancies (Total) _____ # of Miscarriages _____ # of Abortions _____
◻ Presently Pregnant or Breastfeeding ◻ Possibly Pregnant ◻ Change in Libido (Sexual Interest)
◻ Any issues about sexual fulfillment or sexual activity with regard to self or partner?
If yes, please explain:
Have you taken or do you take hormone replacement therapy? ◻ Yes ◻ No
◻ Early loss of ovarian function ◻ Hyperthyroidism ◻ Chronic diarrhea or intestinal malabsorption syndrome
◻ Have you had an eating disorder such as anorexia or bulimia ◻ Low calcium intake ◻ Little or no exposure to sun
◻ High caffeine intake (2-3 cups/day) ◻ Perform physical activity excessively (causing missed periods)
◻ History of inflammatory bowel disease ◻ Obesity ◻ History of colorectal cancer or polyps
◻ Heavy alcohol use ◻ Inactive lifestyle

FOR MEN
◻ Changes in Urinary Stream ◻ Changes in Libido (Sexual Interest)
Methods of Birth Control: ____
Any issues concerning… (check all that apply)
◻ Premature Ejaculation
◻ Erectile Dysfunction
◻ Sexual Activity or Fulfillment with Regard to Self or Partner
◻ If yes, explain: ____
◻ Hyperthyroidism ◻ Chronic diarrhea or intestinal malabsorption syndrome
◻ Have you had an eating disorder such as anorexia or bulimia ◻ Low calcium intake ◻ Little or no exposure to sun
◻ High caffeine intake (2-3 cups/day)
◻ History of inflammatory bowel disease ◻ Obesity ◻ History of colorectal cancer or polyps
◻ Heavy alcohol use ◻ Inactive lifestyle

NUTRITION SURVEY

Please check off and elaborate as necessary.

How would you rate your diet in general?

☐ Very Healthy ☐ Healthy ☐ Moderately Healthy ☐ Unhealthy ☐ Very Unhealthy

Comments: ____

____

Please describe the healthy aspects and unhealthy aspects of your diet:

____

____

Which improvements would you like to achieve:

☐ Lower Salt
☐ Lower Fat, Cholesterol
☐ Less Oil, Mayo, Butter
☐ More Calcium
☐ More Calories, Fewer Calories
☐ More Whole Grains, More Fiber
☐ More Fruits and Vegetables
☐ More Carbohydrates
☐ More Protein
☐ Less Fast Food
☐ Less Alcohol
☐ Less Candy/Chocolate
☐ Fewer Cakes/Pies Cookies
☐ Less Bread, Potatoes, Rice, Pasta
☐ Less Fried Food
☐ Less Snack Food
☐ Less "Junk" Food – Describe
☐ Fewer Carbohydrates
☐ Less Protein
☐ Less Meat, More Fish, More Soy
☐ Smaller Portion Size
☐ Fewer Pesticides

On average what is the total number of servings of fruits and vegetables that you have each day? _____

Which fruits and vegetables do you like? ____

Which fruits and vegetables do you not like? ____

Do any of these apply to you? (check all that apply)

☐ Milk Intolerance ☐ Hypoglycemia ☐ Food Allergies or Other Food Intolerance

Would you like more information about nutrition? ☐ Yes ☐ No

What kind, how can we help you? (please explain)

____

EXERCISE HABITS

Please reply to questions and elaborate as needed.

How would you rate your present exercise habits?

□ Excellent □ Good □ Moderate □ Poor □ Very Poor

Please describe your present exercise habits (type and frequency):

List some of the benefits of exercise:

What have your exercise habits been like in the past?

Do you enjoy exercise? (please comment)

What are some of your goals regarding exercise?

What has allowed you to reach your goals? What keeps you from reaching your goals?

Types of exercise you perform (please circle and comment below):

Swim Walk Jog Run Treadmill Stationary Bike Bicycle Basketball

Baseball Sailing Dance Golf Fitness Classes Tennis Tai Chi

Weight Lifting Handball Gardening Martial Arts House Cleaning

Demanding Physical Labor at Work

Other(s):

____

____

Comments:

____

____

THE EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

SITUATION	CHANCE OF DOZING (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g., a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 & up	Very sleepy and should seek medical advice

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at All	Several Days	More than Half of the Days	Nearly Every Day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating		1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
				PHQ-9 Total Score:	
10	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ___________________ Somewhat difficult _________________ Very difficult _______________________ Extremely difficult _________________			

Q6 CORE 10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7 - Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at All	Several Days	More than Half of the Days	Nearly Every Day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
				GAD-7 Total Score:	