The Rock Creek Wellness Center

Health and Lifestyle Questionnaire

A. Personal Information

1. Name: _____ 2. Date: _____

3. Date of Birth: _____ 4. Age: _____ 5. ___ Male ___ Female

6. Marital Status: ____ Single ____ Married _____ Divorced _____Widowed

7. What is your current occupation? _____

8. Address: _____
_____

7. Phone Numbers (please circle preferred contact number):
   a. Home: _____
   b. Office: _____
   c. Cell: _____

8. Confidential e-mail (to send you confidential medical information): _____
_____

Confidential fax (to send you confidential medical information): _____

9. Weight:
   a. Current Weight: _____
   b. Lowest Adult Weight: _____
   c. Highest Adult Weight: _____

10. Frame Size: _____ Small _____ Medium _____ Large

11. Personal Physician (and phone number):

12. Who lives with you in your household?

13. How would you rate your current health?
____ Poor ____ Average ____ Good ____ Excellent

14. What are your most important expectations and health related goals as a patient at The Rock Creek Wellness Center?

B. Your Past Medical History

15. Please list any surgical procedures you have had (including plastic surgery), along with the approximate date: _____

16. Please list any history of trauma that you have experienced (car accidents, head injuries, broken bones, etc.): _____

17. Please list any medical problems you have had in the past or are currently being treated for:

18. Have you ever had any kind of **cancer** including skin cancer (list type, date, treatment)? _____

19. Please list any diagnostic procedures you have had:

Procedure	When?	For what reason?

19. Have you ever had a blood transfusion? If so, please list when and for what reason:

C. Medications

20. Please list all the medications (prescription and/or over-the-counter) you are currently taking and for what condition:

Medication	For what condition?	Dose (mg):	Times per day:

21. Please list any **drug allergies:** _____

_____

22. Please list all **supplements** (vitamins, herbs, nutritional supplements) you are currently taking and for what condition or you can copy labels and send in with questionnaire:

Supplement	For what condition?	Dose (mg):	Times per day:

D. Family History

Please check the column that applies to each question. Feel free to leave blank any questions you wish to discuss only with the doctor. Is there a history of:

Condition	Does Not Apply	Children	Siblings	Parents	Grand-parents
1. Heart Disease					
2. Cancer					
3. Diabetes					
4. High Blood Pressure					
5. Arthritis					
6. Liver Disease (hepatitis, cirrhosis, etc.)					
7. Psychiatric Illness (depression, anxiety, psychotic disorders, etc.)					
8. Autoimmune Disease (lupus, rheumatoid arthritis, etc.)					
9. Endocrine Gland Disorders (thyroid, adrenal, pituitary)					
10. Neurological Disorders (stroke, seizures, Parkinson's, Alzheimer's, multiple sclerosis, etc.)					
11. Lung Disease (asthma, emphysema, bronchitis, etc.)					
12. Kidney Disease (stones, infections, cysts, etc.)					
13. Stomach/Esophagus Disorders (reflux, stricture, ulcers, etc.)					
14. Bowel Disease (malabsorption, lactose intolerance, diverticulitis, Crohn's, colitis, etc.)					
15. Bladder disease					
16. Substance Abuse (alcohol, prescription, or recreational drugs, tobacco)					
17. Weight Control Problems					
18. Osteoporosis/Weak Bones					
19. Migraine Headaches					
20. Anemia					
21. HIV/AIDS					
22. Allergies					

E. Current Symptoms

For the following categories, please check the symptoms that you are experiencing to a degree that you feel is substantial or unusual.

1. Skin and Hair

Symptom	Yes	No
a. Dry/brittle hair		
b. Dry/brittle skin		
c. Acne		
d. Age spots		
e. Puffy, wrinkled skin		
f. Dark circles under eyes		
g. Hair thinning or falling out or hair grows very slowly		
h. Toe or fingernail fungus		
i. Spider veins in nose and/or face		
j. Persistent rash/skin allergy		
k. Hives		
l. Sores, boils, or sties		
m. Slow or poor wound healing		
n. Excessive sweating or itching		
o. Bruise easily or excessively		

2. Cardiopulmonary

Symptom	Yes	No
a. Chest pain at rest or while walking		
b. Pain in the left arm		
c. Frequent and recurring upper respiratory infections or colds/flu		
d. Fluid retention (e.g., swollen ankles, legs, etc.)		
e. Cannot tolerate much exercise or exhaustion with minor exertion		
f. Difficulty breathing/shortness of breath		
g. Chronic lung congestion		
h. Wheezing		
i. Heaviness in legs		
jl. Calf muscle cramps while walking		
k. Heart misses beats or has extra beats		
l. Rapid heartbeat, fluttering		
m. Heartburn after eating		
n. High blood pressure		
o. Low blood pressure		
p. Breathing problems at night or difficulty lying flat		

3. Allergies

Symptom	Yes	No
a. Seasonal allergies (please describe symptoms):		
b. Food allergies (please list, along with description of reaction)		
c. Latex allergy (please describe reaction):		

4. Metabolic

Symptom	Yes	No
a. Difficulty losing weight/easily gains weight		
b. Easily loses weight/difficulty gaining weight		
c. Overweight or Underweight (circle)		
d. Weight loss of over 10 lbs. in past 6 months		
e. Weight gain of over 10 lbs. in past 6 months		
f. Total blood cholesterol above 200		
HDL cholesterol below 50		
LDL cholesterol above 100		
g. Swollen (bulging) eyes		
h. Hypersensitive to the cold /or cold hands and feet		
i. Crave salt or salty foods/ or sweets (circle)		
j. Wake up in the middle of the night craving sweets		
k. Feel tired or weak if meal is missed		
l. Heart palpitations after eating sweets		
m. Need to drink caffeine to get going		
n. Feel tired 1 to 3 hours after eating		
o. Feel faint or weak		
p. Night sweats		
q. Increase thirsts		
r. Change in appetite		
s. Fatigue		
t. Insomnia		
u. Frequent infections or illness		
v. Sleep apnea		
w. Sleeps too much		
x. Lumps in neck, armpits, groin or breasts		

5. Kidney, Bowels, Bladder and Gastrointestinal

Symptom	Yes	No
a. Frequent urination or scant urination/dribbling		
b. Burning during urination		
c. Loss of bladder control (including leaking)		
d. Hemorrhoids		
e. Excessive nighttime urination (specify number of times)		
f. Loss of bowel control		
g. Blood in urine		
h. Blood in stool		
i. Kidney stones		
j. Frequent urinary tract infections		
k. Diarrhea		
l. Constipation (hard or effortful bowel movements)		
m. Abdominal pain		
n. Nausea and/or vomiting		
o. Heartburn/reflux		
p. Difficulty swallowing or pain with swallowing		
q. Flatulence (gas) or bloating		
r. Gallbladder problems		
s. Dependency on Antacids		

6. Neurological

Symptom	Yes	No
a. Headaches		
b. Faintness		
c. Seizures/convulsions		
d. Tremors		
e. Dizziness		
f. Tingling or numbness		
g. Balance problems		
h. Paralysis		
i. Muscle weakness		
j. Uncoordinated		
k. Difficulty walking		
l. Difficulty speaking		
m. Memory problems		
n. Loss of smell or taste		
o. Problems with attention and concentration		

7. Eyes, Ears, Nose and Throat

Symptom	Yes	No
a. Change in vision: blurred-double-tunnel (circle)		
b. Balance problems		
c. Hearing loss or ringing in the ears (circle)		
d. Ear pain or ear drainage (circle)		
e. Nosebleeds		
f. Sore throat/hoarseness		
g. Recurrent sinus infections		
h. Sore or bleeding gums		
i. Recurrent canker sores or cold sores		

8. Joints, muscle and bones

Symptom	Yes	No
a. Joint pain, swelling or stiffness		
b. Arthritis		
c. Back pain		
d. Muscle tension or spasms		
e. Fibromyalgia		
f. Carpal Tunnel Syndrome		
g. Osteoporosis or osteopenia (circle)		

9. Mind and Emotions

Symptom	Yes	No
a. Rapid mood swings		
b. Irritable/short temper/anger		
c. Lack of mental alertness		
d. Depression		
e. Anxiety/fear		
f. Lack of self-esteem		
g. Difficulty with memory, attention, or concentration		
h. Sleep disturbances		
i. Excessive worrying		
j. Suicidal thoughts		
k. Confusion/poor comprehension		
l. Difficulty making decisions		
m. Excessive stress		
n. Restlessness, hyperactivity, or inability to relax		
o. Weakness, fatigue, or loss of energy		

10. For Men Only

Symptom	Yes	No
a. Difficulty maintaining/attaining an erection		
b. Premature ejaculation or painful ejaculation		
c. Sexual drive underactive		
d. Sexual drive overactive		
e. Infertility or low sperm count		
f. Varicose veins on scrotum		
g. Discharge from penis		
h. Past or present rash on penis		
i. Swollen genitals or groin		
j. Past or present sexually transmitted disease (specify):		
k. Jock itch		

Medication Usage	Yes	No
l. Do you use Viagra/Levitra/Cialis? If yes, how often? If yes, has it helped you? m. Do you use any other medication for sexual function? If yes, please list and describe results:		

Test Dates	Results
n. Date of last complete physical examination:	
o. Date of last prostate exam:	
p. Date of last PSA:	
q. Date of last colonoscopy (or sigmoidoscopy):	
r. Date of last rectal exam:	
s. Date of last stress EKG (Treadmill Stress Test):	
t. Date of last chest X-ray:	
u. Date of last eye exam/eye pressures:	
v. Date of last Dexa (bone density) Scan:	

11. For Women Only

Symptom	Yes	No
a. If still having periods:		
Last menstrual period, date of first day: _____		
Menstrual pain/cramping		
Heavy menstrual bleeding		
Irregular periods or skipped periods		
PMS		
Monthly weight gain or bloating		
b. Form of birth control: None Pill IU Diaphragm Foam partner's vasectomy Condoms Tubal Ligation or Hysterectomy		
c. Pregnancies: total # _____ live births _____ miscarriages _____ sex/age of children:		
d. Infertility		
e. Menopause? what age: _____ Symptoms: Hot flashes/night sweats/sweating throughout the day (circle) Vaginal dryness Underactive sex drive (low libido) Memory or concentration problems Weight gain or fluid retention (circle)		
f. History of hysterectomy? If yes, when and why?		
g. Dislike of intercourse		
h. Overactive sex drive		
i. Pelvic/ovarian/vaginal pain or soreness		
j. Tender breasts		
k. Vaginal itching		
l. Vaginal discharge or sores		
m. Past or present sexually transmitted disease (specify):		
n. History of ovarian cysts or uterine fibroids (circle)		
n. History of endometriosis		
Test Dates	**Results**	
o. Date of last complete physical exam:		
p. Date of last pap smear/pelvic exam:		
q. Date of last breast exam:		
r. Date of last mammogram:		
s. Date of last colonscopy (or sigmoidoscopy):		
t. Date of last rectal exam:		
u. Date of last stress EKG (Treadmill Stress Test):		
v. Date of last chest X-ray:		
w. Date of last eye exam/eye pressures:		
x. Date of last Dexa (bone density) Scan:		

F. Lifestyle Summary

1. How many alcoholic beverages do you consume in an average week (including beer and wine)? 2. How many caffeinated beverages do you drink per day? Coffee _____ Tea _____ Sodas: diet _____ reg. _____ 3. How many glasses of water do you drink per day?	4. For Past and Present Tobacco Users: a. Do you currently use tobacco? _____ Yes _____ No b. If Yes, what type? (circle all that apply): Cigarettes Pipe Snuff Cigars Chewing tobacco c. How much per day? d. If you previously used tobacco – what did you use? Cigarettes Pipe Snuff Cigars Chewing tobacco e. How much per day on average? f. For how long? g. When did you quit? h. How many times have you quit?
5. Have you ever used any illegal drugs? Please explain what and when:	
6. What are your hobbies?	
7. Do you travel outside the country? Yes _____ No _____ If yes, please list countries you have visited in the last 5 years:	
8. Do you consider yourself to be under a great deal of stress? Please explain:	
9. Are you on any special diets?	
10. How many hours per week do you watch TV?	

G. Exercise Summary

1. How often do you engage in aerobic exercise (walking, jogging, biking, swimming)?
   a. Times per week: _____
   b. Length of each exercise period: _____
   c. Please describe your routine: _____
   _____
   _____

2. How often do you engage in flexibility and/or stretching exercises (yoga, tai chi, stretch and toning classes, brief stretching after aerobics or weights)?
   a. Times per week: _____
   b. Length of each stretching period: _____
   c. Please describe your routine: _____
   _____
   _____

3. How often do you participate in resistance/strength training exercises (free weights, weight machines, body pump classes, water aerobics)?
   a. Times per week: _____
   b. Length of each exercise period: _____
   c. Please describe your routine: _____
   _____
   _____

4. Fitness Activity Assessment

Question	Yes	No
a. Are you currently involved in an exercise program?		
d. Are you currently a member of a health club?		
e. Have you ever worked with a personal trainer?		
f. If yes, for how long? Did you enjoy it?		
g. Are you still with a personal trainer?		
h. Do you have any exercise equipment at home (bike, treadmill, free weights, etc.)? If yes, please list:		

I have completed this form to the best of my knowledge. I understand that wellness services are provided for enhancement of my general health. I understand the services are not treatment for medical conditions and injuries. I understand the services in no way take the place of a primary doctor's care, and I will seek proper medical care if it is indicated. The information provided is understood to be educational and to be used at my own discretion. I understand the services provided are for wellness promotion and there are no guarantees regarding specific goals and outcomes.

Date _____ Signature _____