SunridgeMedical
WELLNESS CENTER

Personal Health Information

Please take a few moments to fill out the information below as completely as possible. Your answers will help our physicians and clinical staff prepare for your assessment and will assist us in developing a customized health strategy.

PERSONAL

Prefix (Mr., Mrs., Ms., Dr., etc.) First Name Middle Last Suffix (Jr., Sr.)

Preferred Name (If different from your first name)

Address City State Zip Country

Gender: Male/Female Social Security Number Date of Birth

Home Phone Work Phone Cell Phone

Preferred phone number to contact you: ☐ Home ☐ Work ☐ Cell

Home E-mail Address Work E-mail Address

Preferred method of communication: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Home E-mail ☐ Work E-mail

May we send our informative upcoming Sunridge Medical Client Newsletter to you via: ☐ E-mail ☐ Regular Mail

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African-American ☐ Asian ☐ Native American
☐ Multi-racial ☐ Unknown ☐ Decline to answer ☐ Other___________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

EMPLOYMENT

Are you employed? ☐ Yes ☐ No

If yes, Employer Name___________________________

What is your occupation title?___________________________

REFERRAL INFORMATION

Where you referred to Sunridge? ☐ Yes ☐ No

If yes, referred by: ☐ Friend ☐ Physician ☐ Relative ☐ Client ☐ Other ___________________

Referring Person's name: ___________________________

If no, how did you hear about us? : ☐ Internet ☐ Magazine ☐ Phonebook ☐ Newspaper ☐ Other

EMERGENCY INFORMATION

First Name Middle Last Suffix (Jr., Sr.)

Personal Health Information

What is his/her relationship to you? ______

Emergency Phone: ______ Alternative Phone: ______

INSURANCE

Are you eligible for Medicare benefits? ☐ Yes ☐ No Medicare Number: ______

Primary Insurance Company

Company Name: ______ Plan Type/Number ______

Company Address: ______

Company Phone: ______ ID Number: ______

Policy Number: ______ Group Number: ______

Policy Holder: ______ Relationship to Insured: ______

Employer (If policy through Employer): ______

Notes/Changes: ______

CLIENT INTERESTS

Please take the time to advise us on your personal interests. Please check those that apply.

- ☐ Cooking
- ☐ Reading
- ☐ Playing Musical Instruments
- ☐ Photography
- ☐ Performing Arts
- ☐ Card Clubs
- ☐ Music
- ☐ Volunteering
- ☐ Crafts
- ☐ Collecting
- ☐ Gardening
- ☐ Travel
- ☐ Fine Dining
- ☐ Spa Days
- ☐ Exercise
- ☐ Sports
- ☐ Other ______

PHYSICIANS

Primary Care Physician

First Name ______ Last ______

Specialty ______

Address ______

City, State, Zip ______

Office Phone ______

Specialist Physician

First Name ______ Last ______

Specialty ______

Address ______

City, State, Zip ______

Office Phone ______

GOALS

Please rank your top three health plan goals (1-3) and place a check mark next to any remaining goals.

- ☐ Improve cognitive function
- ☐ Improve depression
- ☐ Improve overall health
- ☐ Improve Sleep
- ☐ Increase energy
- ☐ Improve sports performance
- ☐ Increase muscle mass
- ☐ Maintain lean body mass
- ☐ Minimize symptoms of fatigue
- ☐ Minimize symptoms of menopause
- ☐ Overall education
- ☐ Reduce risk of Alzheimer's/dementia
- ☐ Reduce cancer risk
- ☐ Reduce risk of cardiovascular disease
- ☐ Reduce risk of diabetes
- ☐ Reduce risk of osteoporosis
- ☐ Stabilize mood
- ☐ Other ______

What do you consider your ideal weight? ______

FAMILY HISTORY

Has anyone in your immediate family (blood relative) ever had any of the following diseases or conditions?

☐ **Diabetes**

Select the relationship(s) of the person(s) with the ailment:

☐ Father ☐ Father's Family ☐ Mother ☐ Mother's Family ☐ Sister ☐ Brother ☐ Child ☐ Other ☐ None

☐ **Cancer**

Select the relationship(s) of the person(s) with the ailment:

☐ Father ☐ Father's Family ☐ Mother ☐ Mother's Family ☐ Sister ☐ Brother ☐ Child ☐ Other ☐ None

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If anyone in your immediate family has had cancer, please specify type of cancer:

☐ Breast ☐ Lung ☐ Leukemia ☐ Pancreas ☐ Cervical ☐ Lymphoma ☐ Prostate ☐ Skin
☐ Colon/Rectal ☐ Oral ☐ Stomach ☐ Uterine ☐ Kidney ☐ Ovarian ☐ Brain ☐ Liver
☐ None ☐ Other______________________________

☐ **Heart Attack or Hardening of the Arteries**

Select the relationship(s) of the person(s) with the ailment:

☐ Father ☐ Father's Family ☐ Mother ☐ Mother's Family ☐ Sister ☐ Brother ☐ Child ☐ Other ☐ None

Approximate age of diagnosis:__________

☐ **High Blood Pressure**

Select the relationship(s) of the person(s) with the ailment:

☐ Father ☐ Father's Family ☐ Mother ☐ Mother's Family ☐ Sister ☐ Brother ☐ Child ☐ Other ☐ None

☐ **Kidney Disease**

Select the relationship(s) of the person(s) with the ailment:

☐ Father ☐ Father's Family ☐ Mother ☐ Mother's Family ☐ Sister ☐ Brother ☐ Child ☐ Other ☐ None

☐ **Stroke**

Select the relationship(s) of the person(s) with the ailment:

☐ Father ☐ Father's Family ☐ Mother ☐ Mother's Family ☐ Sister ☐ Brother ☐ Child ☐ Other ☐ None

☐ **Other**______________________________

Select the relationship(s) of the person(s) with the ailment:

☐ Father ☐ Father's Family ☐ Mother ☐ Mother's Family ☐ Sister ☐ Brother ☐ Child ☐ Other ☐ None

ALLERGIES

Please select the drug(s), if any, to which you have a known allergy:

☐ ACE inhibitor (e.g analapril, lisinopril) ☐ Allopurinol ☐ Amoxicillin
☐ Ampicillin ☐ Anti-inflammatory drugs (e.g. Motrin, Advil) ☐ Aspirin
☐ Carbamazepine (e.g. Tegretol) ☐ Cephalosporine (e.g. Keflex, Ancef) ☐ Erythromycin
☐ Nitrofuratoin (e.g. Macrodantin) ☐ Penicillin or penicillin-type antibiotics ☐ Phenytoin (e.g. Dilantin)
☐ Sulfa drugs (e.g. Bactrim, Septra) ☐ I have no known drug allergies ☐ Other ____________________

Select the reaction(s) to the **drug(s)** to which you are allergic:

☐ Diarrhea ☐ Difficulty Breathing ☐ Extremity/facial swelling ☐ Fever ☐ Hives ☐ Nausea
☐ Swollen Tongue ☐ Rash ☐ Other ______________________________

Select the **food(s)** to which you are allergic:

☐ Beets ☐ Chocolate ☐ Milk or Dairy ☐ Grains ☐ Peanuts ☐ Shellfish ☐ Strawberries
☐ None ☐ Other ______________________________

Select your reaction(s) to the **foods(s)** to which you are allergic:

☐ Diarrhea ☐ Difficulty Breathing ☐ Extremity/facial swelling ☐ Fever ☐ Hives ☐ Nausea
☐ Swollen Tongue ☐ Rash ☐ Other ______________________________

Please select the **environmental condition(s)** to which you have a known allergy:

☐ Fiber ☐ Grass ☐ Household cleaners ☐ Mold ☐ Pets ☐ Pollen
☐ Trees ☐ None ☐ Other ______________________________

Select your reaction(s) to the **environmental allergen(s)** to which you are allergic:

☐ Diarrhea ☐ Difficulty Breathing ☐ Extremity/facial swelling ☐ Fever ☐ Hives ☐ Nausea
☐ Swollen Tongue ☐ Rash ☐ Other ______________________________

Please indicate any **other** known allergens:______________________________

Select your reaction(s) to the **above other allergen(s)**:

☐ Diarrhea ☐ Difficulty Breathing ☐ Extremity/facial swelling ☐ Fever ☐ Hives ☐ Nausea
☐ Swollen Tongue ☐ Rash ☐ Other ______________________________

MEDICATIONS AND SUPPLEMENTS

List the medication(s) or supplement(s) that you are currently taking. ☐ None

Medication/Supplement ______________________ Dosage/Frequency ______________________
Medication/Supplement ______________________ Dosage/Frequency ______________________
Medication/Supplement ______________________ Dosage/Frequency ______________________

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Medication/Supplement ______ Dosage/Frequency ______
Medication/Supplement ______ Dosage/Frequency ______
Medication/Supplement ______ Dosage/Frequency ______
Medication/Supplement ______ Dosage/Frequency ______
Medication/Supplement ______ Dosage/Frequency ______

HEIGHT/WEIGHT

Height: ______ Current Weight (lbs): ______ Weight 1 year ago (lbs): ______

Have you ever had problems with your weight, please describe the problem:

☐ 30% over your recommended weight ☐ Anorexia ☐ Binge eating ☐ Eat to gain weight
☐ Eat to lose weight ☐ Bulimia ☐ Unable to gain weight ☐ Rapid/unexplained weight loss ☐ None

IMMUNIZATIONS

Have you had a tetanus booster within the last 10 years? ☐ Yes ☐ No
If yes, date of last booster? ______
If no, have you received the Varicella (chicken pox) immunization? ☐ Yes ☐ No
Have you had the Pneumococcal vaccine? ☐ Yes ☐ No
Have you had the Hepatitis A vaccine? ☐ Yes ☐ No
Have you had the Hepatitis B vaccine? ☐ Yes ☐ No
Do you have annual flu shots? ☐ Yes ☐ No

MALE ONLY

If you are known to have had any abnormalities of the prostate, please select any that may apply:

☐ Benign prostatic hypertrophy (enlarged prostate or BPH) ☐ Prostate cancer ☐ Prostate infections
☐ None ☐ Other ______

Please select any prostate procedures you have had:

☐ PSA (prostate specific antigen) ☐ Resection ☐ TURP ☐ None ☐ Other

Have you had any problems with erections? Check all that apply:

☐ Difficulty maintaining erections ☐ Erections are soft ☐ Unable to achieve erections ☐ N/A ☐ Other ______

Have you had any procedures done for an erection problem?
If yes, what? ______

Please select any problem(s) you have had with your testicles:

☐ Chronic pain ☐ Lumps ☐ Tumor ☐ None ☐ Other ______

Have you had any procedures done for a testicle problem? ☐ Yes ☐ No
If yes, what? ______

Sexual preference: ☐ Male ☐ Female ☐ Both ☐ Abstain

FEMALE ONLY

Age at first period: ______ Date of last period: ______ Age at menopause: ______
Age of mother at menopause if known: ______ Number of pregnancies: ______ Number of abortions: ______
Number of live births: ______ Number of miscarriages: ______ Number of children adopted: ______

Date of last mammogram: ☐ Can't remember ☐ More than one year ago ☐ Never had one ☐ Within the last year
Mammogram results: ☐ Abnormal ☐ Normal ☐ Don't know ☐ N/A

If you have had an abnormal mammogram, what was the follow-up? ☐ Biopsy ☐ Repeat mammogram ☐ Surgery ☐ Ultrasound

Follow-up results: ☐ Fibrocystic disease ☐ Malignant ☐ Tumor ☐ Other ______

Date of last Pap smear: ☐ Can't remember ☐ More than one year ago ☐ Never had one ☐ Within the last year
Results of Pap smear: ☐ Abnormal ☐ Borderline ☐ Normal ☐ Don't know

If you have had an abnormal Pap smear, what was the follow-up?

☐ Conization ☐ Cryosurgery ☐ Laser Surgery ☐ Repeat Pap ☐ Return exam in 3 months
☐ None ☐ Other ______

Follow-up results: ☐ Fibrocystic disease ☐ Malignant ☐ Tumor ☐ Other ______

Do you have any gynecologic problems? Check all that apply:

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☐ Abnormal bleeding ☐ Endometriosis ☐ Herpes ☐ HPV/Warts ☐ Hysterectomy ☐ Ovarian cysts
☐ Ovaries removed ☐ Tubal surgery ☐ Sexually transmitted disease ☐ None ☐ Other ________

Sexual preference: ☐ Male ☐ Female ☐ Both ☐ Abstain

EYES

Do you wear corrective lenses? ☐ Yes ☐ No

Date of last eye exam? ☐ Never had an eye exam ☐ Over a year ago ☐ Within 3 months ☐ Within 6 months ☐ Within a year

Have you ever had eye surgery? ☐ Yes ☐ No

If you lack vision, in which eye do you lack vision? ☐ Left ☐ Right ☐ Both ☐ N/A

Do you have or experience any of the following?

☐ Blurred vision ☐ Cataracts ☐ Change in vision ☐ Double vision ☐ Pain behind your eye ☐ Glaucoma
☐ Frequent eye infections ☐ Retinal Problems ☐ Spots before your eyes ☐ N/A ☐ Other________

EARS

Do you have hearing loss? ☐ Left ear ☐ Right ear ☐ None

Do you wear a hearing aid? ☐ Left ear ☐ Right ear ☐ None

Do you have or experience any of the following?

☐ Drainage from your ears ☐ Earaches ☐ Recurrent infections ☐ Ringing in your ears ☐ N/A ☐ Other________

NOSE

Do you have or experience any of the following?

☐ Allergic rhinitis ☐ Earaches ☐ Frequent colds ☐ Hay fever ☐ Post-nasal drip ☐ N/A ☐ Other________

THROAT

Do you have or experience any of the following mouth- or throat-related problems?

☐ Difficulty swallowing ☐ Enlarged glands ☐ Loss of taste ☐ Persistent hoarseness
☐ Recurrent mouth sores ☐ Recurrent sore throats ☐ Severe gum problems ☐ Severe teeth problems
☐ N/A ☐ Other ________

LUNGS

Do you experience shortness of breath during any of these activities?

☐ Daily walking ☐ Laying down ☐ Climbing stairs ☐ N/A ☐ Other________

If you had pneumonia, what was the diagnosis?

☐ Bacterial ☐ Fungal ☐ Viral ☐ N/A ☐ Other ________

Do you suffer from any of the following lung-related problems?

☐ Asthma ☐ Chronic coughing ☐ Recurrent infections ☐ Chronic Bronchitis ☐ Tuberculosis
☐ Cough up blood ☐ Pleurisy ☐ Tuberculosis ☐ N/A ☐ Other ________

Have you ever had any of the following treatments for an abnormal chest X-ray?

☐ Biopsy ☐ Bronchoscopy ☐ CT or CAT scan ☐ I have never had an abnormal chest x-ray

Results of test ________

Treatment ________

HEART

If you have been diagnosed with heart disease, what was the diagnosis?

☐ Angina (chest pain) ☐ Cardiac Arrest ☐ Cardiomyopathy ☐ Congestive Heart Failure
☐ Coronary Artery Disease ☐ Heart attack ☐ Heart valve problems ☐ Murmurs
☐ Peripheral Vascular Disease ☐ Other ________

Heart Diagnosis Treatment

☐ Angioplasty ☐ Angioplasty with stent(s) ☐ Diet ☐ Coronary artery bypass (CABG) ☐ Exercise
☐ Surgery other that CABG ☐ None ☐ Other ________

Do you experience swelling in any of these areas?

☐ Ankles ☐ Feet ☐ Hands ☐ None ☐ Other________

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Do you have or experience any of the following heart-related problems?

☐ Blood clots in legs/lungs ☐ Cold/numb feet ☐ Enlarged veins in legs ☐ Fainting spells ☐ Heart murmur
☐ Irregular pulse ☐ Leg cramps ☐ Pain of pressure in chest ☐ Palpitations ☐ Phlebitis (vein inflammation)
☐ None ☐ Other ______

If you have abnormal or high blood fats (cholesterol, triglycerides), what was the treatment?

☐ Diet ☐ Exercise ☐ Medications ☐ None ☐ Other ______

If you have been diagnosed with **high** blood pressure, what was the treatment?

☐ Diet ☐ Exercise ☐ Medications ☐ N/A ☐ Other ______

If you have been diagnosed with **low** blood pressure, what was the treatment?

☐ Diet ☐ Exercise ☐ Medications ☐ N/A ☐ Other ______

GASTROINTESTINAL

If you have been diagnosed with liver disease/hepatitis, what was the diagnosis?

☐ Autoimmune hepatitis ☐ Cirrhosis ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
☐ I do not have liver disease/hepatitis ☐ Other ______

Describe your appetite: ☐ Present ☐ Absent ☐ Always hungry

What food do you avoid? ☐ Acidic ☐ Spicy ☐ I do not avoid any foods ☐ Other ______

Do you have any experience with any of the following gastrointestinal problems?

☐ Blood in stool ☐ Change in bowel movements ☐ Cirrhosis ☐ Colitis ☐ Colon Polyps ☐ Constipation
☐ Cramping ☐ Crohn's Disease ☐ Diarrhea ☐ Hemorrhoids ☐ Hernia ☐ Jaundice ☐ Nausea
☐ Pancreas problems ☐ Vomiting ☐ I do not have gastrointestinal problems ☐ Other ______

KIDNEY / UROGENITAL

Have you experienced or been diagnosed with any of the following kidney/urogenital problems?

☐ Bed wetting ☐ Blood in urine ☐ Difficulty starting urination ☐ Frequent or painful urination
☐ Increased urination at night ☐ Loss of urine on coughing ☐ Protein in urine ☐ Recurrent bladder infections
☐ Recurrent kidney infections ☐ Urinate less that before ☐ Urinate more than before ☐ Urgency
☐ I don't have any problems

MUSCULOSKELETAL

If you have arthritis, please select the diagnosis: ☐ Osteoarthritis ☐ Rheumatoid ☐ None ☐ Other ______

If you have arthritis, what joints are involved?

☐ Feet ☐ Hands ☐ Hip-left ☐ Hip-right ☐ Knee-left ☐ Knee-right ☐ Spine
☐ Neck ☐ Other ______

Please list the location of any broken bones you have had ______

If you have bursitis, please list the joints involved ______

If you have a deformity, please select the location: ☐ Bone ☐ Joint ☐ Spine ☐ None ☐ Other ______

Have you experienced or been diagnosed with any of the following musculoskeletal conditions?

☐ Backaches ☐ Dislocations ☐ Foot trouble ☐ Gout ☐ Joint swelling
☐ Osteoporosis ☐ Pain is shoulder or elbow ☐ Recurrent back pain ☐ Recurrent sprains ☐ Redness or hot joints
☐ Tremors ☐ Muscle spasms ☐ I do not have musculoskeletal problems ☐ Other ______

SKIN

Have you experienced or been diagnosed with any of the following skin conditions?

☐ Acne ☐ Dermatitis ☐ Dry skin ☐ Eczema ☐ Growth or cysts ☐ Rashes ☐ Shingles
☐ Skin cancer ☐ Sores ☐ I do not have any skin problems ☐ Other ______

NERVOUS SYSTEM

Have you ever had a head injury? ☐ Yes ☐ No

Do you have permanent problems from the injury? ☐ Yes ☐ No

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If yes, what? ______

Have you had a stroke/TIA (mini-stroke)? ☐ Yes ☐ No

If yes, have you had any permanent problems from the stroke? ☐ Yes ☐ No

If yes, what? ______

Have you experienced or been diagnosed with any of the following nervous system conditions?

☐ Chronic headaches ☐ Cluster headache ☐ Difficulty sleeping ☐ Difficulty with concentration
☐ Problems with memory ☐ Experienced paralysis ☐ Dizzy spells ☐ Frequent headaches
☐ Loss of sensation in hands and feet ☐ Memory Loss ☐ Migraine headaches ☐ Periods of unconsciousness
☐ Seizures ☐ Tingling in hands or feet ☐ Weakness in hands or feet ☐ Other ______

ENDOCRINE

If you have been diagnosed with diabetes, please indicate the type:

☐ Gestational (only during pregnancy) ☐ Type 1 ☐ Type 2 ☐ N/A

Describe current treatment:

☐ Diet ☐ Exercise ☐ Insulin ☐ Oral Medication ☐ None ☐ Other ______

Have you experienced or been diagnosed with any adrenal problems? ☐ Yes ☐ No

If yes, what? ______

If you have been diagnosed with hypoglycemia, at what frequency?

☐ Many times a day ☐ Once a day ☐ Once a week ☐ I do not have hypoglycemia ☐ Other

If you have hypoglycemia, what is the treatment? ______

Have you experienced or been diagnosed with any pancreas problems? ☐ Yes ☐ No

If yes, what? ______

If you are known to have thyroid problems, please indicate the diagnosis?

☐ Euthyroid ☐ Graves' Disease ☐ Hyperthyroid ☐ Hypothyroid ☐ Hashimoto's ☐ Nodules
☐ I do not have thyroid problems ☐ Other ______

Have you experienced or been diagnosed with any pituitary problems? ☐ Yes ☐ No

If yes, what? ______

BLOOD

If you are known to have any blood/bleeding problems, please give the diagnosis:

☐ Anemia Hemophilia ☐ High/low blood cells ☐ High/low platelets ☐ Increased red blood cell count
☐ Polycythemia ☐ I do not have blood/bleeding problems ☐ Other ______

Do you bruise easily? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No Approximate year ______

INFECTIONS

If you have ever contracted any STDs (sexually transmitted diseases), please indicate which ones:

☐ Gonorrhea/Chlamydia ☐ Herpes ☐ Syphilis ☐ Warts ☐ None ☐ Other ______

If you have been diagnosed with an immune system disorder, please indicate the type:

☐ Chronic infections (3 or more per year) ☐ Recurring infections (same location 2-3 times a year) ☐ HIV/AIDS
☐ I do not have an immune system problem ☐ Other ______

MENTAL HEALTH

If you are known to have had or now have a psychiatric illness, what was the diagnosis?

☐ Agitation ☐ Anorexia ☐ Anxiety ☐ Attention Deficit Disorder (ADD) ☐ Bulimia ☐ Depression
☐ Moodiness ☐ Nervousness ☐ Panic attacks ☐ Phobias ☐ Schizophrenia ☐ Suicidal thought
☐ I do not have a psychiatric problem ☐ Other ______

CANCER

Have you had any of the following cancer warning signs?

☐ Change in bowel or bladder habits ☐ Change in freckle or mole ☐ Chronic indigestion or difficulty in swallowing
☐ Persistent cough ☐ Persistent sore throat ☐ Thickening of lump in breast ☐ Unexplained weight loss
☐ Unusual bleeding or discharge ☐ None

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Do you have an annual colon/rectal screening? ☐ Yes ☐ No
If yes, date of last exam? ____________
What type of screening?
☐ Colonoscopy ☐ Flexible Sigmoidoscopy ☐ Test for blood in stools ☐ X-rays ☐ Other
If you have ever been diagnosed with cancer, please indicate the type:
☐ Breast ☐ Cervical ☐ Colon/rectum ☐ Kidney ☐ Leukemia ☐ Lung ☐ Lymphoma ☐ Oral
☐ Ovarian ☐ Pancreas ☐ Prostate ☐ Skin ☐ Stomach ☐ Uterine ☐ None
Indicate your current status if you have/had cancer:
☐ Cured ☐ In remission ☐ Receiving treatments ☐ Other ____________
If you have ever had cancer, what type of treatment(s) did you receive?
☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ None ☐ Other
Have you ever had a full-body X-ray scan (electron beam or CAT scan)? ☐ Yes ☐ No
If yes, what was the result? ____________

ACCIDENTS

If you have had an accident requiring hospitalization or surgery, what type was it?
☐ Bad fall ☐ Bicycle accident ☐ Car accident ☐ Gunshot wound
☐ I have had no accident requiring hospitalization or surgery ☐ Other ____________
If you have had an accident, what was the severity?
☐ Required ER visit ☐ Required hospitalization ☐ Required hospitalization and surgery ☐ Other ____________

SURGERY

If you have had surgery(s), please choose all that apply:
☐ Appendectomy ☐ Back/Spine ☐ CABG (coronary artery bypass graft) ☐ Cancer ☐ Cosmetic surgery
☐ Ear, nose, throat ☐ Tonsils ☐ Fracture repairs ☐ Gallbladder ☐ Hernia ☐ Hysterectomy
☐ Joint replacement or repairs ☐ Lumpectomy ☐ Mastectomy ☐ Orthopedic
☐ Prostatectomy ☐ Stomach ☐ N/A ☐ Other ____________

If you have had fracture repair, please specify where the fracture was:
☐ Arm ☐ Back ☐ Leg ☐ Neck ☐ I have not had a fracture repair ☐ Other ____________
If you have had joint replacement or repairs, please specify which joint:
☐ Ankle ☐ Elbow ☐ Hip ☐ Knee ☐ Shoulder ☐ I have not had a joint replacement ☐ Other ____________

STRESS/EXERCISE

Please rate your present level of stress: ☐ High ☐ Medium ☐ Low ☐ Other ____________
Has stress ever caused you to be physically ill? ☐ Yes ☐ No
If yes, how? ____________
How do you handle stress?
☐ Crying ☐ Exercise ☐ Getting angry at myself ☐ Getting angry at others ☐ Laughing ☐ Meditation ☐ Other ____________
Do you meditate regularly? ☐ Yes ☐ No
Do you pray regularly? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No
If yes, how frequently? ☐ 3 or more days a week ☐ Less than 3 days a week
If you exercise, what type?
☐ Aerobic ☐ Resistance training ☐ Tai Chi ☐ Walking ☐ Yoga ☐ Other ____________
If no, are you interested in starting an exercise program? ☐ Yes ☐ No
How often do you do cardiovascular exercise?
☐ 3 or more times per week ☐ less that 3x per week ☐ Not at all
How often do you do resistance training?
☐ 3 or more times per week ☐ less that 3x per week ☐ Not at all
How often do you do flexibility training?
☐ 3 or more times per week ☐ less that 3x per week ☐ Not at all

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DIET

Describe your diet type:

☐ Diabetic ☐ Gluten-Free ☐ High Protein ☐ Lactose-Free ☐ Low-Fat ☐ Low Salt

☐ Regular ☐ Low Carbohydrates ☐ Other ______

ALCOHOL

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type, how much and how often?

TOBACCO

Have you ever smoked cigarettes, cigars, marijuana or a pipe? ☐ Yes ☐ No

If yes, how long did you/have you smoked? ______

If yes, do you still smoke? ☐ Yes ☐ No Year you quit smoking:

What do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other ______

How much do you smoke?

☐ Less than 1 pack of cigarettes per day ☐ Regular pipe/cigar smoking (every day) ☐ More than 1 pack of cigarettes per day

☐ Periodic pipe/cigar smoking (once a week) ☐ Other ______

Have you ever used chewing tobacco? ☐ Yes ☐ No

If yes, how long did you/have you used chewing tobacco? ______

If yes, do you still use chewing tobacco? ☐ Yes ☐ No

By signing below, you, the patient of Sunridge Medical (or the legal representative or parent of the patient), are requesting and authorizing Sunridge Medical Wellness Center to perform services and to provide you with recommendations on optimizing your present and long-term health goals. The assessment may include screening tests, such as a DEXA scan, RMR, treadmill stress test, fitness test, H-Scan, static balance test, audiometer, glaucoma, or blood draw. You may decline to take any test. There are risks associated with the tests, including but are not limited to abnormal blood pressure, fainting, dizziness, heart rhythm changes, heart attack, stroke, death, soreness, bruising and discomfort.

- I accept these risks. Initial ______
- I agree to accept responsibility for payment of all charges relating to the services provided to me, regardless of the outcomes of the services or whether any insurance applies. Initial ______
- You agree that your anonymous test results and demographic data may be included in the Sunridge Medical central database and may be used for research purposes. Initial ______

If you have provided your e-mail address, Sunridge Medical will communicate with you concerning Center programs and activities through e-mail. For e-mail communication concerning your personal health results or concerns, you must sign and provide to Sunridge Medical a "Consent to E-Mail Communication" form.

____

Client Signature Date

____

Print name