

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: \_\_\_\_\_

## CLIENT INTERESTS

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

- |  |                                     |  |                                       |
|--|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Cooking         | <input type="checkbox"/> Reading    | <input type="checkbox"/> Playing Musical Instruments | <input type="checkbox"/> Photography  |
| <input type="checkbox"/> Performing Arts | <input type="checkbox"/> Card Clubs | <input type="checkbox"/> Music                       | <input type="checkbox"/> Volunteering |
| <input type="checkbox"/> Crafts          | <input type="checkbox"/> Collecting | <input type="checkbox"/> Gardening                   | <input type="checkbox"/> Travel       |
| <input type="checkbox"/> Fine Dining     | <input type="checkbox"/> Spa Days   | <input type="checkbox"/> Exercise                    | <input type="checkbox"/> Sports       |
| <input type="checkbox"/> 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.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Improve cognitive function          | <input type="checkbox"/> Improve depression             | <input type="checkbox"/> Improve overall health                | <input type="checkbox"/> Improve Sleep           |
| <input type="checkbox"/> Increase energy                     | <input type="checkbox"/> Improve sports performance     | <input type="checkbox"/> Increase muscle mass                  | <input type="checkbox"/> Maintain lean body mass |
| <input type="checkbox"/> Minimize symptoms of fatigue        | <input type="checkbox"/> Minimize symptoms of menopause | <input type="checkbox"/> Overall education                     |  |
| <input type="checkbox"/> Reduce risk of Alzheimer's/dementia | <input type="checkbox"/> Reduce cancer risk             | <input type="checkbox"/> Reduce risk of cardiovascular disease |  |
| <input type="checkbox"/> Reduce risk of diabetes             | <input type="checkbox"/> Reduce risk of osteoporosis    | <input type="checkbox"/> Stabilize mood                        | <input type="checkbox"/> 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

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

- |  |                               |                                   |                                   |                                   |                                   |                                   |                                |
|--|-------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Breast                                    | <input type="checkbox"/> Lung | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Cervical | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Prostate | <input type="checkbox"/> Skin  |
| <input type="checkbox"/> Colon/Rectal                              | <input type="checkbox"/> Oral | <input type="checkbox"/> Stomach  | <input type="checkbox"/> Uterine  | <input type="checkbox"/> Kidney   | <input type="checkbox"/> Ovarian  | <input type="checkbox"/> Brain    | <input type="checkbox"/> Liver |
| <input type="checkbox"/> None <input type="checkbox"/> 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

# Personal Health Information

## 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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ACE inhibitor (e.g. analapril, lisinopril) | <input type="checkbox"/> Allopurinol                                  | <input type="checkbox"/> Amoxicillin               |
| <input type="checkbox"/> Ampicillin                                 | <input type="checkbox"/> Anti-inflammatory drugs (e.g. Motrin, Advil) | <input type="checkbox"/> Aspirin                   |
| <input type="checkbox"/> Carbamazepine (e.g. Tegretol)              | <input type="checkbox"/> Cephalosporine (e.g. Keflex, Ancef)          | <input type="checkbox"/> Erythromycin              |
| <input type="checkbox"/> Nitrofuratoin (e.g. Macrochantin)          | <input type="checkbox"/> Penicillin or penicillin-type antibiotics    | <input type="checkbox"/> Phenytoin (e.g. Dilantin) |
| <input type="checkbox"/> Sulfa drugs (e.g. Bactrim, Septra)         | <input type="checkbox"/> I have no known drug allergies               | <input type="checkbox"/> Other _____               |

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

- Diarrhea     Difficulty Breathing     Extremity/faceal 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/faceal 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/faceal 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/faceal 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 \_\_\_\_\_

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

## Personal Health Information

### 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? \_\_\_\_\_

### 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:

- Abnormal bleeding
  Endometriosis
  Herpes
  HPV/Warts
  Hysterectomy
  Ovarian cysts  
 Ovaries removed
  Tubal surgery
  Sexually transmitted disease
  None
  Other \_\_\_\_\_

### 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 \_\_\_\_\_

# Personal Health Information

## 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 than CABG
- None
- Other \_\_\_\_\_

Do you experience swelling in any of these areas?

- Ankles
- Feet
- Hands
- None
- Other \_\_\_\_\_

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 \_\_\_\_\_

## Personal Health Information

### 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 than 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 in 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

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

## Personal Health Information

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

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

# Personal Health Information

- 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

## 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

# Personal Health Information

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.

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Client Signature

Date

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Print name