



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

REFERRAL INFORMATION

Were 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 Last Name

What is his/her relationship to you? _____

Emergency Phone: _____

Alternative Phone: _____

First Name Last Name

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.

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

GOALS

Primary reason for visit: _____

Please take time to advise us on your goals. Please check those that apply.

- | | | |
|-------------------------------------|-------------------------------|----------------------------|
| Improve cognitive function | Reduce risk of osteoporosis | Reduce headaches/migraines |
| Increase energy | Improve overall health | Reduce joint pain |
| Minimize symptoms of fatigue | Reduce cardiovascular disease | Reduce food allergies |
| Improve depression | Improve sleep | Improve digestive issues |
| Minimize symptoms of menopause | Improve memory | Other _____ |
| Reduce cancer risk/ care for cancer | Stabilize mood | |

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:

- | | | | | | | | |
|--------------|-------------|----------|----------|----------|----------|----------|-------|
| 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:

Personal Health Information

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. Macrochantin)	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 _____
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

Personal Health Information

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

Difficulty maintaining erections	Erections are soft	Unable to achieve erections	N/A	Other _____
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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 _____
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Have you had any procedures done for a testicle problem?

Yes	No
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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:

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?

Personal Health Information

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 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

Personal Health Information

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
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 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
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Describe current treatment:

Diet	Exercise	Insulin	Oral Medication	None	Other _____
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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?

Personal Health Information

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

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?

Personal Health Information

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	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

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_____

Personal Health Information

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