COAST MEDICAL CENTER WELLNESS AND LIFESTYLE ASSESSMENT

Date: ________________________________

Name: ____
Last First Middle Initial

Address: _____________________________ _______________________________________
Street City State Zip

Home Phone: ____________________ **Work:**_____________________ **Fax:**_________________

Best Phone number to reach you: _____________________**SSN:**________-_______-____________

Email: __________________________ **Mobile phone/other:** _____________________________

Date of Birth:____________________ **Age:** ______**Sex:**_____ **Height:** _____ **Weight:** _______

Marital Status: ___________ **Number of Children:** ___ **Occupation:** _________________________

Pets (please list): ____

Emergency Contact: ______________________________ **Relationship:** _____________________

Address: ____

Telephone: ____________________ **Email:** _______________________________

PRIMARY INSURANCE INFORMATION

Primary Ins.Co.: _________________________ ID#: ______________________________

Insurance Address: ____

Group#: ____________________ Relationship to Insured: ___________________________

DOB:____________________ Male ☐ Female ☐

SECONDARY INSURANCE INFORMATION

Primary Ins.Co.: _________________________ ID#: ______________________________

Insurance Address: ____

Group#: ____________________ Relationship to Insured: ___________________________

DOB:____________________ Male ☐ Female ☐

YOU ARE RESPONSIBLE FOR ANYTHING YOUR INSURANCE COMPANY DOES NOT COVER. ALL COPAYS ARE DUE AND PAYABLE AT THE TIME OF YOUR APPOINTMENT. THE FOLLOWING FEE'S MAY APPLY.

☐ **$5 FEE FOR COPAYS NOT AT THE TIME OF SERVICE**

☐ **$50 NO SHOW FEE OR LATE CANCELLATION (LESS THAN 24 HOURS)**

☐ **$35 NSF FEE FOR ANY RETURNED CHECK FROM THE BANK.**

(Please initial in the boxes & sign below)

Signature:____ **Date:** __________________

ALLERGIES (please describe your symptoms):
Seasonal allergies (hay fever, other) **Medication allergies (rash, other)**

____
____
____

SECTION ONE: Past Medical History – SELF *(circle all that apply to you)*

Neurological
Headaches
Stroke
Parkinson's
Memory Problems
Alzheimer's
Head Injury
Insomnia
Other_______________________________

Cardiovascular
Heart Disease
Heart Attack
Angina
Blood Clots in legs
Varicose Veins
Other_______________________________

Auto Immune
Lupus
Rheumatoid Arthritis
Crohn's Disease
Fibromyalgia
Other_______________________________

Liver Disease
Hepatitis
Cirrhosis
Other_______________________________

Endocrine
Thyroid
Diabetes
Adrenals
Pituitary
Other_______________________________

Gastrointestinal
Ulcers
Malabsorption
Diverticulosis
Lactose Intolerance
Other_______________________________

Respiratory
Asthma
Emphysema
Other_______________________________

General
Glaucoma
Epstein Barr
Chronic Fatigue Syndrome
Other_______________________________

Musculoskeletal
Arthritis
Osteoporosis
Back or Spine Problems
Carpal Tunnel Syndrome
Other_______________________________

Cancer
Where _______________________________

What kind ___________________________

When _______________________________

Mental Concerns
Depression
Anxiety
Schizophrenia
ADD
Bipolar

HIV/AIDS (symptoms – please explain)
____
____
____

Alcoholism
Other_______________________________

Genitourinary
Kidney Stones
Impotence
Infertility
Menopause
Fibroids
Endometriosis
Other_______________________________

Other/Explain-
____
____
____

Surgical procedures- (please list any and all major or minor surgical procedures and the dates the procedures were performed):
____
____
____

Date of last chest x-ray ______________________________
Date of last Pap smear/pelvic exam ______________________________
Date of last mammogram ______________________________
Date of last Pelvic Ultrasound ______________________________
Date of last Bone density ______________________________
Date of last digital-rectal exam ______________________________
Date of last PSA/prostate exam ______________________________
Date of last colonoscopy/sigmoidoscopy ______________________________
Date of last cardiac stress test and/or EBCT ______________________________

SECTION TWO: Medical History – FAMILY

FAMILY MEMBER	STATUS Alive Dead Unknown (circle which one applies)	CURRENT AGE OR AGE AT DEATH	MEDICAL HISTORY
Mother	Alive Dead Unknown		
Father	Alive Dead Unknown		

Siblings	Alive Dead Unknown		
Children	Alive Dead Unknown		
Grandchildren	Alive Dead Unknown		

SECTION THREE: Your Social History

Where were you born? ______________________________
Where did you grow up? ______________________________
What kinds of work have you done? ______________________________
What kind of work do you do now? ______________________________
How many hours do you work each day? ______________________________
What are your hobbies? ______________________________
What brings you the greatest joy in your life? ______________________________
Other: ______________________________

SECTION FOUR: DRUG USE

Marijuana use (how long, how often) ______________________________
Alcohol use (how long, how often) ______________________________
Tobacco use (what type, how long, how often) ______________________________
Cocaine use (mode, how long, how often) ______________________________
Psychedelic drug use (Ecstasy, LSD, other) ______________________________
Other recreational drug use (what type, how long, how often) ______________________________

SECTION FIVE: NUTRITION

How many meals do you eat per day? ____________________
How much water do you drink a day? ____________________

What type of diet are you eating? (circle one)

Zone Diet (40% favorable carbohydrates, 30% favorable proteins, 30 % favorable fats)
Atkins Diet (high protein, high fat, low carbohydrates)
Low Carb. Diet (50% carbohydrates, 30% proteins, 20% fats)

Vegetarian Diet (circle one)
Vegan (plant products only)
Lactovegetarian (plant and dairy products)
Ovolactovegetarian ((plant, dairy, egg products)
Fruitarian (fruits, nuts, honey and vegetable oils)
No mammal diet
Other
If other, please explain ____

Coffee Number of cups per day ____
Tea Type and number of cups per day ____________________________________
Soft Drinks/Diet Drinks Type and amount per day ____________________________________
Do you eat foods containing large amounts of sugar? Yes No
Do you use artificial sweeteners such as Equal, Sweet-n-Low or Sucralose? Yes No
Do you use a microwave to cook or reheat your food? Yes No

Typical Daily Food Intake:

List all food consumed in the last TWO days. If these days are not typical, pick two days that are most typical of your eating patterns. Please be specific, including amount of foods and beverages.

MEAL **TIME** **FOOD & AMOUNT** **BEVERAGE & AMOUNT**

BREAKFAST (________) ____

____

SNACK (________) ____

____

LUNCH (________) ____

____

SNACK (________) ____

____

DINNER (________) ____

____

SNACK (________) ____

____

MEAL **TIME** **FOOD & AMOUNT** **BEVERAGE & AMOUNT**

BREAKFAST (________) ____

____

SNACK (________) ____

____

LUNCH (________) ____

____

SNACK (________) ____

____

DINNER (________) ____

____

SNACK (________) ____

____

Food Allergies:

List any Food Allergies that you have (be specific and be sure to include ALL food allergies)

____

____

SECTION SIX: EXERCISE

What type of exercise do you do? (circle all that apply)
None Aerobic Resistance training Flexibility training
Please list your specific form(s) of exercise:
How many times do you exercise each week? (circle one)
0 1-3 3-5 5-7 Greater than 7
When you exercise, how long are your exercise sessions: (circle one)
15-30 minutes 30-45 minutes 45-60 minutes 60-75 minutes 75-90 minutes 90 minutes or greater
After exercising, is your energy better or worse? ___________________
During your exercise sessions is your energy level stable? If not explain. ______________________________

SECTION EIGHT: SPIRITUAL
Religion ______________________________ Do you practice this religion? _______________________
Other (please explain) ____

SECTION NINE: MEDICATION and NUTRITIONAL SUPPLEMENT UTLIZATION

Please list the name(s), dosage, frequency and duration of all medications that you are taking:

NAME	DOSAGE	FREQUENCY	HOW LONG?

Please list the dosage, frequency and duration of all nutritional supplements that you are taking:

VITAMINS, NUTRITIONAL SUPPLEMENTS, OVER THE COUNTER HORMONES

NAME	DOSAGE	FREQUENCY	HOW LONG?

SECTION TEN - REVIEW OF SYSTEMS (circle all that apply)

GENERAL	NONE	
	decreased energy	fever
	weakness	chills
	fatigue	night sweats
	decreased appetite	sleeping pattern change
	weight increase	other
SKIN	NONE	increased Body Odor
	skin infections	skin color changes
	rashes	changes in hair
	nail changes	acne
	itchy skin	excessive sweating
	wrinkles	facial hair
	varicose veins	other
HEMATOPOIETIC	NONE	
	easy bruising	swollen glands
	abnormal bleeding	other
	anemia	
ENDOCRINE	NONE	
Thyroid	cold hands	swollen/bulging eyes
	cold intolerance	body temp less than 97.6 F
	eyebrow thinning lateral third	difficulty gaining weight
	gain weight easily	
Diabetes	craving for sweets	irritability if meal missed
	frequent urination	palpitations after sweets

Adrenals	extreme thirst	night sweats
	discoloration in lines on palms	crave salt or salty foods
	weakness with standing	other
CENTRAL NERVOUS SYSTEM	NONE	syncope
	headache	Trouble walking
	Double vision	tremor
	dizziness	paralysis
	seizure disorder	pain
	tingling, numbness	other
EYES	NONE	glaucoma
	vision loss	excessive tearing
	glasses	excessive redness
	contacts	other
	eye surgeries	
EARS	NONE	drainage
	pain	surfer's ear
	hearing loss	other
	Ringing in the ears	
NOSE,THROAT SINUSES	NONE	freq sore throats
	trouble swallowing	nose bleeds
	voice changes	tumors
	nasal drainage	other
	sinusitis	
TEETH AND GUMS	NONE	periodontal problems
	dentures	bleeding gums
	abscesses	other
	bad breath	
RESPIRATORY	NONE	Frequent colds
	shortness of breath	Blood in your sputum
	pneumonia	Chest pain with breathing
	cough	positive PPD
	wheezing	other
CARDIOVASCULAR	NONE	
	chest pain with exertion/angina	abnormal blood pressures
	chest pain with rest	Heart beating too fast/irregular
	Trouble breathing when lying down	myocardial infarction
	Shortness of breath with exertion	congestive heart failure
	Shortness of breath at night	syncope
	heartburn after eating	pain in left arm
	leg cramps/heaviness with walking	other
GASTROINTESTINAL	NONE	
	abdominal pain	diarrhea
	change in bowel habits	constipation
	flatus	blood in stool
	nausea	black stools
	vomiting	dyspepsia
	heartburn	hemorrhoids
	Vomiting blood	food intolerances

	bloating	other
URINARY TRACT	NONE	
	Painful urination	Nighttime Urination once
	Blood in your urine	twice
	frequency	3 +
	hesitancy	decreased stream
	dribbling or loss of bladder control	kidney stones
	frequent infections	other
MUSCULOSKELETAL	NONE	osteoporosis
	Muscle pains	deformity
	Joint pains	back pain
	arthritis	limitation of movement
	edema	other
REPRODUCTIVE MALE	NONE	
	Sexually transmitted disease	infertility/low sperm count
	testicular masses	past or present penile rash
	discharge from penis	other
REPRODUCTIVE FEMALE	NONE	
	vaginal discharge	birth control:
	vaginal dryness	oral contraceptives/ring
	pain with intercourse	IUD
	ovarian cysts	diaphragm
	uterine fibroids	condom
	endometriosis	tubal ligation
	breast lumps	vasectomy
	painful breasts	other:
	heavy menstrual cycle	
	irregular/missed menstrual cycle	
	light, scanty cycle	
	menstrual pain	infertility
		hot flashes/night sweats
		night sweats
		water retention
		insomnia
	Number of pregnancies	cyclical headaches
	Number of children	moodiness/irritability
	Number of Miscarriages	lower backache
	Number of Abortions	leg cramps and tenderness
	sexually transmitted diseases	other
PSYCHIATRIC	NONE	nightmares
	anxiety	hallucinations
	insomnia	suicidal thoughts
	depression	homicidal thoughts
	use of antidepressants	rapid mood swings
	nervousness	short attention span
	difficulty concentrating	outbursts of anger
	fear of losing control	other