THE FUNCTIONAL HEALTH & WELLBEING CENTER AT OSS HEALTH

Please use the attached form to provide details on your personal health and wellness. Once completed, you can print out and bring to the office **at least two days prior to your appointment** or upload as a PDF using the Spruce mobile app and submit to your R-Health care team.

PLEASE DO NOT E-MAIL THIS FORM AS IT CONTAINS PERSONAL HEALTH INFORMATION.

Personal Health Survey

Date:_____

First Name _____ **Last Name** _____ **Phone** _____ **DOB** _____

Address _____ **City** _____ **State** _____ **Zip** _____

E-mail: _____

In case of emergency: _____ **Phone:** _____

Gender: _____

Gender Identity: _____

Race/ethnicity: ❑ White/Caucasian ❑ Black/African-American ❑ Native American ❑ Asian or Pacific Islander ❑ Hispanic/Latino ❑ Multi-ethnic ❑ Other

Relationship Status: ❑ Single ❑ Married ❑ Divorced ❑ Other_____

Do you live alone: ❑ Yes ❑ No

Highest Education Level:_____

Pharmacy: _____ **Phone Number:** _____
(Name & Address)

Please let us know of any current health goals you may have.

1. PERSONAL MEDICAL HISTORY

Height: ____ FT _____ INCHES Current Weight: _____ LBS

Are you currently pregnant? ❑ Yes ❑ No ❑ No, but I have given birth within the last 18 months.
Are you currently breastfeeding? ❑ Yes ❑ No

Which of the following conditions are you currently being treated for or have you ever been treated for?
(please check the box)

Past	Present		Past	Present		Past	Present	
❑	❑	Heart Stents	❑	❑	Periodontal disease	❑	❑	Glaucoma
❑	❑	Cataracts	❑	❑	Macular degeneration	❑	❑	Sleep apnea
❑	❑	High cholesterol	❑	❑	Asthma	❑	❑	Seizures
❑	❑	Low blood pressure	❑	❑	Emphysema	❑	❑	Stroke
❑	❑	High blood pressure	❑	❑	Sinusitis	❑	❑	Migraine headaches
❑	❑	Heartburn/ acid reflux	❑	❑	Seasonal allergies	❑	❑	Neurological problems
❑	❑	Anemia	❑	❑	Gout	❑	❑	Depression
❑	❑	Insomnia	❑	❑	Osteoporosis	❑	❑	Other mental health diagnosis
❑	❑	Diabetes	❑	❑	Frequent urinary infections	❑	❑	Diverticulitis
❑	❑	Pre-diabetes				❑	❑	Liver problem/hepatitis
❑	❑	Arthritis	❑	❑	Kidney problems	❑	❑	Restless legs
❑	❑	Thyroid Problems	❑	❑	Cancer (type _____)	❑	❑	Prostate problems
❑	❑	Corrective lenses/glasses	❑	❑	Sexually Transmitted Disease	❑	❑	Rheumatic fever
❑	❑	Hernia				❑	❑	Eating disorder
❑	❑	Bleeding/Clotting problems	❑	❑	Hearing loss	❑	❑	Blood Transfusion
❑	❑	Aortic Aneurysm	❑	❑	Kidney stones	❑	❑	Peripheral artery disease
❑	❑	Breast Cancer/Chemotherapy	❑	❑	Polycystic Ovarian Syn	❑	❑	Obesity
❑	❑	High BP during pregnancy	❑	❑	Alcoholism			
❑	❑	Heart Attack	❑	❑	Psoriasis			
			❑	❑	Erectile Dysfunction			
			❑	❑	Anxiety			

Please list other medical conditions, mental health conditions, or provide additional details.

Please date any immunizations that you have had:

Zostavax_____ **Influenza**_____ **Pneumovax**_____
HPV_____ **Tetanus**_____ **Hep A**_____
Hep B_____ **TB skin test**_____ **Other** _____

Please list any past/upcoming surgeries or hospital admissions.

Surgery/Hospitalizations: *Date:*

2. TAKING MEDICATION

Have you been recommended to take a medication by your healthcare provider in the last few years? ❑ **Yes** ❑ **No**

If yes, please answer the questions below. Healthcare providers such as doctors, physician assistants and nurse practitioners often recommend over-the-counter or prescription medications for their patients.

	Yes	No
1. Within the past few years, have you ever decided not to begin a medication your healthcare provider has recommended?	❑	❑
2. Within the past few years, have you ever decided to stop taking a recommended medication for reasons such as side effects, cost, inconvenience or because you felt it was not necessary?	❑	❑
3. Do you tend to forget to take your medications once or more per week?	❑	❑
4. Do you usually follow instructions when taking your medications? (At the right time? Correct amount? On a full empty stomach? Not with particular foods or liquids?)	❑	❑
5. Would you like to learn more about options that might help you take your medications correctly and on time?	❑	❑

Current Prescription and Over-the-counter Medications, Vitamins and Herbs: (Please include dosages)

Medication	*Dosage*	*Start Date*	*Reason*

Please list any drug allergies or other allergies.

3. FAMILY MEDICAL HISTORY

Please indicate the conditions that have ever been present in a blood relative such as a brother, sister, mother, father, or grandparent. IF yes, please CIRCLE if mother (M), father (F), sister (S), brother (B), grandfather (GF) and/or grandmother (GM).

	Yes	No	I don't know
Diabetes	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
High Blood Pressure	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Stroke	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
High cholesterol	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Depression	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Cancer (not including skin cancer)	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Heart Attack	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Other Heart Condition	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Asthma	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Chronic Bronchitis/Emphysema/Lung Conditions	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Osteoporosis	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Arthritis	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑
Allergies	❑ **(M)(F)(S)(B)(GF)(GM)**	❑	❑

Please list other medical conditions, mental health conditions, or provide additional details regarding your family history

4. SCREENINGS AND EXAMS

Please answer each question and select only one answer for each question. When answering these questions, think about the results of your last screening or examination.

	Yes (normal)	Yes (abnormal)	No	Date
1. Have you had a physical exam or check-up by your healthcare provider in the last 12 months?	❑	❑	❑	_____
2. Have you had a tetanus shot within the last 10 years?	❑	❑	❑	_____
3. Do you receive the influenza (flu shot) vaccine annually?	❑	❑	❑	_____
4. Have you had a colon cancer screening within the past 10 years? (A colon cancer screening can include any of the following: colonoscopy, barium enema, sigmoidoscopy or a hemoccult card for blood in the stool.)	❑	❑	❑	_____
5. Have you had a blood test for cholesterol within the past five years?	❑	❑	❑	❑
6. Have you had a hemoglobin A1C (sugar) level tested in the past three years?	❑	❑	❑	❑

Women Only

	Yes (normal)	Yes (abnormal)	No	Date	N/A
1. If you're over 50, do you have a mammogram every one to two years?	❑	❑	❑	_____	❑ (Mastectomy)
2. If you're between the ages 21-65, do you have a Pap smear every one to three years?	❑	❑	❑	_____	❑ (Hysterectomy)
3. If you're post-menopausal, have you had a bone density screening for osteoporosis?	❑	❑	❑	_____	

Men Only

	Yes (normal)	Yes (abnormal)	No	Date
1. If you're over 50, have you ever had a prostate cancer screening, or have you had a conversation about it with your doctor?	❑	❑	❑	_____

	Yes	No
1. If the results of any of the past screens, tests or exams listed were not normal, have you followed your healthcare provider's recommendations about treatment and future testing?	❑	❑

5. EMOTIONAL HEALTH

While completing the questions in this section, please consider how you have felt during the past 30 days.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
1. How often have you found yourself stressed or worried about your personal finances, such as not being able to pay you your bills?	❑	❑	❑	❑	❑
2. How often have you found yourself stressed or worried about a health problem that you or a loved one is experiencing?	❑	❑	❑	❑	❑
3. How often have you found yourself stressed or worried about a relationship problem within your family or with a friend or neighbor?	❑	❑	❑	❑	❑
4. How often have you found yourself stressed or worried about problems at work?	❑	❑	❑	❑	❑

Stress management includes regular relaxation, physical activity, talking with others or making time for social activities.

Do you effectively practice stress management in your daily life? *(select one)*

- ❑ No, and I do not intend to in the next 6 months.
- ❑ No, but I intend to in the next 6 months.
- ❑ No, but I intend to in the next 30 days.
- ❑ Yes, I have been for more than 6 months.
- ❑ Yes, but for less than 6 months.
- ❑ I currently don't have any stress in my life.

If yes, please explain your methods in practicing stress management.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
1. How often have you felt sad, down, blue or depressed?	❑	❑	❑	❑	❑
2. How often have you had decreased interest in hobbies, work, socializing or activities that usually give you pleasure?	❑	❑	❑	❑	❑

	Yes	No
1. Would you like to learn more about options that might help you manage your stress?	❑	❑
2. Would you like to learn more about options that might help you with sadness or depression?	❑	❑

	Yes	No
1. Do you feel safe at home?	❑	❑
2. Have you ever experienced physical or emotional abuse?	❑	❑

6. SLEEP

Approximately how many hours of uninterrupted sleep do you average per night?
Do not include the time you may get out of bed or lay awake.

❑ 4 or less ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 or more

	Yes	No
1. Do you feel refreshed with this current amount of sleep?	❑	❑
2. Do you consider the quality of your sleep to be good?	❑	❑
3. During the past 30 days, have you felt you've had enough energy?	❑	❑
4. Has anyone told you that you snore or have stopped breathing in your sleep?	❑	❑
5. Would you like to learn more about options that might help you improve your sleep?	❑	❑

7. PHYSICAL ACTIVITY/EXERCISE

1. Do you do some form of movement daily? Yes ❑ No ❑

2. For how long?

❑ Less than 10 minutes
❑ 10 to 19 minutes
❑ 20 to 29 minutes
❑ 30 to 44 minutes
❑ 45-59 minutes
❑ 60 minutes or more
❑ Other _____

3. How many days a week do you do physical activity?

❑ Zero days ❑ 1 day ❑ 2 days ❑ 3 days ❑ 4 days ❑ 5 days ❑ 6 days ❑ 7 days

4. Please list a few of the activities you do to stay active.

5. During a typical week, on how many days do you intentionally increase your activity level by going for walks, parking farther away, or taking the stairs rather than an elevator?

❑ Zero days ❑ 1 day ❑ 2 days ❑ 3 days ❑ 4 days ❑ 5 days ❑ 6 days ❑ 7 days

6. How many hours per day do you sit? Please consider time at work and at home and include activities such as sitting in front of a computer or television.

❑ None ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7 or more

	Yes	No
7. Would you like to learn more about options that might help you become more physically active?	❑	❑

8. NUTRITION

1. Do you follow a specific dietary plan? (ex. Vegan, gluten-free, lactose-free) If so, please describe_____

2. During a typical week, how many meals do you eat at a fast-food, casual dining or sit down restaurant?

❑ Never ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7 or more

3. How many naturally or artificially sweetened beverages do you consume per day? Please include regular and diet soft drinks, energy, sports drinks, and juice.

❑ Never ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7 or more

4. What did you eat/drink yesterday?

Breakfast:
Lunch:
Dinner:
Snacks:

Is this a typical meal for you? ❑ Yes ❑ No

	Yes	**No**
5. Do you read the Nutrition Facts panel on food labels?	❑	❑
6. If yes, do you feel comfortable interpreting what you read on the label?	❑	❑
7. Do you plan to improve your diet during the next 6 months?	❑	❑
8. Would you like to learn more about options to improve your eating habits?	❑	❑

9. WEIGHT MANAGEMENT

1. Are you happy with your current weight?
   ❑ Yes ❑ No, I would like to lose weight during the coming year.
   ❑ No, I would like to gain weight during the coming year.

	Yes	No
2. Have you maintained your desired weight for more than 6 months?	❑	❑
3. Would you like to learn more about options that might help you lose/gain weight?	❑	❑

10. TOBACCO USE

8. Have you ever used tobacco products? Yes ❑ No ❑
9. Are you currently using tobacco products? Yes ❑ No ❑
10. How much did you smoke / do you smoke currently?:_____
11. Have you quit, or have plans to quit? Yes ❑ No ❑ If yes, when: _____
12. Are you interested in quitting? Yes ❑ No ❑
13. Please check the tobacco products you've used / are using.

❑ Cigarettes
❑ Cigars
❑ Cigarillos
❑ Electronic cigarettes
❑ Hookahs
❑ Bidis
❑ Chewing tobacco
❑ Snuff
❑ Other:_____

13. Do you live with someone who smokes? ❑ Yes ❑ No

11. ALCOHOL/DRUG USE

1. Do you drink alcohol? Yes ❑ No ❑
2. How many drinks do you have on a typical day? ❑ Zero ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 or more
3. How many drinks do you have on a typical week? ❑ Zero ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 or more
4. How many drinks do you have on a typical month? ❑ Zero ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 or more
5. Are you concerned with your drinking? Yes ❑ No ❑
6. Do you use recreational drugs? Yes ❑ No ❑
7. Would you like to learn more about options that might help you eliminate or cut back on your alcohol/drug use?

Yes ❑ No ❑