

Health Risk Assessment Form

This information is necessary to aid your physician in understanding your medical history, risk factors, and symptoms. The information you provide is an essential part of your examination and provides the basis for your diagnosis and treatment. Therefore, it is important that you read each question carefully and provide complete and accurate answers. IF YOU DO NOT WISH TO ANSWER A QUESTION, PLEASE LEAVE BLANK. PLEASE COMPLETE FORM BEFORE YOUR VISIT!

Name: _____
Last First Middle
Phone Work: _____ Home: _____ Cell: _____ Date: _____

Current Medical History

1. How do you rate your current health? Excellent _____ Good _____ Fair _____ Poor _____
2. What is your main medical problem or concern?
3. Are there other medical problems of concern?
4. Who are your referring or current doctors? Who was your previous physician? (Please have copies of important prior records and labs forwarded)
5. What medications are you on? What dosage and frequency? Please include supplements.

Past Medical History

1. What operations have you had (give date if known)? Include tonsillectomy, appendectomy, hernia repair, gynecological procedures, plastic surgery, as well as major surgery.
2. What hospitalizations have you had for non-surgical illnesses?
3. What other major illnesses have you had?
4. What medications are you allergic to (give reaction if known)?
5. What other foods or items are you allergic to?

Family History

(Circle Y for Yes, N for No)

1. Is your mother living? Y N If yes, how old is she? _____ If no, age at death _____
Major medical problems in your mother: _____
2. Is your father living? Y N If yes, how old is he? _____ If no, age at death _____
Major medical problems in your father: _____
3. Please list each brother and sister by age and medical problems:
4. Do you have an identical twin? Y N If yes, list medical problems:
5. What blood relatives have had any of the following medical problems: high blood pressure, diabetes, angina, heart attack/myocardial infarction, stroke, tuberculosis, osteoporosis?
6. Have any blood relatives had medical problems before the age of 40 years? Y N Which relative and what medical problems?

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7. Please list blood relatives with a history of cancer and the type of cancer:

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Health Risks

(Circle Y for Yes, N for No)

Weight

1. What do you regard as your ideal weight? _____pounds
2. Are you at that weight, underweight, or overweight?
3. What health problems do you attribute to any weight concerns?
4. What contributes to problems in your weight? (Travel, snacks, business lunches, lack of exercise, pregnancy, other _____)
5. Are you trying to lose weight now? Y N If yes, how?
6. Have you ever had an eating disorder? Y N

Cholesterol/lipid level

1. Have you had your cholesterol/lipids checked? Y N Were they elevated?
2. Do you know your most recent results for HDL_____ LDL_____ Triglyceride _____?
3. Are you on a diet to limit your fat intake to lower your cholesterol/lipids?
4. Do you take vitamins, niacin, red yeast rice or other medications for your cholesterol/lipids? Y N If yes, specify type and dosage:
5. Do you have any health problems related to your cholesterol/lipids?

Diet

1. Is your diet usually healthy? Y N
2. Is your intake of fat or cholesterol low_____ moderate_____ high_____? Do you limit your intake of fat or cholesterol? Y N
3. How many eggs do you use a week?
4. How much milk do you drink daily?_____ Is it whole, 2%, 1%, or nonfat? _____
5. Do you limit your intake of salt, meat, or other items?
6. How much caffeine containing beverages (coffee, tea, cola) do you drink a day? _____ What side effects do you have from caffeine containing beverages?
7. Do you drink wine, beer, or hard liquor? Y N If yes, how often? Daily_____ Several times a week_____ Rarely_____
8. Do you have any health problems from alcohol use?
9. Please list vitamins and daily dosages: Vitamin C:_____ Vitamin E :_____ Calcium : _____ Vitamin D :_____ Other supplements not listed on page 1?

Stress

1. Do you sleep well at night? Y N How many hours do you get nightly?
2. Do you handle and control the stress in your life? Y N
3. How many hours do you drive a day?
4. Is your work a source of excess stress for you? Y N
5. Do you consider yourself compulsive, easily upset, or frequently depressed?
6. Were you ever the victim of violence or abuse, either physical or emotional? Y N If yes, are you at risk now? Y N What problems have you had related to this?

Sexual Activity and Risk Profile

1. Have you ever had sex? Y N If yes, have you had sex with men, women, or both? (circle)
2. Are you having usual sexually active currently? Y N Are you using contraception? Y N
3. Have you ever been tested for HIV? Y N Results_____ Last Tested_____
4. Have you every used intravenous drugs? Y N Have you ever had a blood transfusion? Y N
5. Have you had sexual relations with men who have sex with men? Y N Don't Know
6. Do you use latex condoms during intercourse? Y N
7. Have you ever been treated for sexually transmitted diseases? Y N Have you had venereal warts? Y N Genital herpes? Y N Do you have any STD symptoms or concerns? Y N

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Exercise

- 1. How often do you exercise? Never... Rarely... 1 to 3 times a month... Once to 3 times a week... 4 to 6 times a week... Daily (7 times a week)
2. Average time spent per session: ...minutes How strenuous? Mild Moderate Vigorous
3. Do you set aside a specific time to exercise or just "fit it in"?
4. Which activities do you participate in? Aerobics... Jogging... Bicycle riding... Swimming... Tennis... Golf... Treadmill... Weight machines... Stairmaster... Walking... Gardening... Free weights... Other... Yoga... Pilates
5. What symptoms, if any, do you have when you exercise?

Smoking

- 1. Do you currently smoke cigarettes? Y N If yes, how many a day? ... How many years have you smoked?
2. If you don't smoke now, have you smoked in the past? Y N If yes, how many a day? ... How many years did you smoke? ... When did you quit?
3. Have you smoked a pipe or cigar? Y N Do you still smoke? ... If yes, how much?
4. Have you chewed tobacco? Y N For how long? ... Do you still use it? Y N
5. Are you exposed to second hand smoke? Y N

Health Habits

- 1. Do you wear a seat belt /shoulder harness every time you ride in a car? Y N
2. Do you ever ride in a car when the driver (including yourself) has been drinking? Y N
3. When was your last complete physical examination?
4. Are your immunizations up to date for: tetanus/diphtheria? Y N Influenza? Y N Pneumococcal vaccine? Y N Mumps/Measles/Rubella (did you have these illnesses)? Y N
5. Men - do you do testicular self-exam monthly? Y N
6. Men - have you had a prostate specific antigen (PSA) blood test? Y N If yes, result?
7. Women - do you do monthly breast self-exam? Y N Have you had a mammogram? Y N If yes, what were the results and when was it last done?
8. Women - when was your last Pap test? ... Have you ever had an abnormal pap smear? Y N If yes, what treatment did you receive?
9. Have you ever had a stress test? Y N If yes, results?
10. Have you ever had a sigmoidoscopy or colonoscopy? Y N If yes, reason and results?
11. Do you use any over the counter medications? Y N Which medications, and for what?

Health Concerns

- 1. Are there specific medical problems that you wish to discuss?
2. Are there any health concerns that were not addressed?
3. Additional comments:
4. What is your home address:
5. What is your birth date: ___/___/___
6. What is your email address: (PRINT)
7. What is your profession?
8. Where would you prefer messages be left? _____

Signature: _____ Date: _____

System Review

(Do you have a past or present history of any of the following?)

<u>Dermatologic</u>	Past	Present	<u>Cardiovascular</u>	Past	Present.
Change in skin growth	_____	_____	Chest discomfort at rest	_____	_____
Hives	_____	_____	Chest discomfort with activity	_____	_____
Rash	_____	_____	Angina or coronary heart disease	_____	_____
Psoriasis	_____	_____	Heart attack/myocardial infarction	_____	_____
Skin cancer	_____	_____	Heart surgery/bypass	_____	_____
<u>Eyes, Ears, Nose, Throat</u>			Rheumatic heart disease	_____	_____
Decreased hearing	_____	_____	Valve disease or damage (heart murmur)	_____	_____
Glasses or contacts	_____	_____	Abnormal EKG (electrocardiogram)	_____	_____
Glaucoma	_____	_____	Congenital heart disease	_____	_____
Change in vision	_____	_____	Irregular heart beat	_____	_____
Sinus disorder	_____	_____	Rapid heart beats	_____	_____
Post nasal drip	_____	_____	Skipped beats	_____	_____
Frequent cold or flu	_____	_____	Dizziness or fainting	_____	_____
Thyroid condition	_____	_____	High blood pressure	_____	_____
Difficulty swallowing or change in voice	_____	_____	Congestive heart failure	_____	_____
<u>Pulmonary</u>			Edema or swelling of ankles	_____	_____
Shortness of breath with activity	_____	_____	Shortness of breath when lying down flat	_____	_____
Wheezing or asthma	_____	_____	Shortness of breath with activity	_____	_____
Chronic cough	_____	_____	Blood clots in legs	_____	_____
Blood streaked sputum	_____	_____	Leg discomfort with walking/ Claudication	_____	_____
Recurrent bronchitis	_____	_____	Varicose veins	_____	_____
Emphysema	_____	_____	Atrial fibrillation	_____	_____
			<u>Childhood illnesses</u>		
Lung cancer	_____	_____	Chicken pox	_____	_____
Abnormal chest X-ray	_____	_____	Scarlet fever	_____	_____
Tuberculosis or + skin test	_____	_____	Polio	_____	_____

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System Review

(Do you have a past or present history of any of the following?)

<u>Endocrine</u>	Past	Present	<u>Genitourinary</u>	Past	Present.
Diabetes (sugar)	_____	_____	Pain/difficulty urinating	_____	_____
Low blood sugar	_____	_____	Reduced urine stream/dribbling	_____	_____
Overactive thyroid	_____	_____	Kidney stone	_____	_____
Underactive thyroid	_____	_____	Urinary frequency	_____	_____
Goiter (enlarged thyroid)	_____	_____	Nocturia/urinating after bedtime	_____	_____
Elevated cholesterol	_____	_____	Prostate enlargement	_____	_____
Adrenal disease	_____	_____	Prostate infection	_____	_____
<u>Gastrointestinal</u>			Recurrent bladder infections	_____	_____
Recurrent nausea	_____	_____	Kidney infection	_____	_____
Recurrent vomiting	_____	_____	Blood in urine	_____	_____
Indigestion	_____	_____	Testicular swelling or mass	_____	_____
Heart burn/hyperacidity	_____	_____	Vasectomy	_____	_____
Hiatal hernia/reflux	_____	_____	<u>Gynecologic</u>		
Ulcer/stomach bleeding	_____	_____	Age of menstruation onset	_____	_____
Change in bowel movements	_____	_____	Heavy periods	_____	_____
Black stools/blood in stools	_____	_____	Irregular periods	_____	_____
Colon polyps	_____	_____	Painful periods	_____	_____
Hepatitis/jaundice	_____	_____	Age of menopause	_____	_____
Gallstones	_____	_____	Hysterectomy	_____	_____
Hemorrhoids	_____	_____	Ovarian disease or surgery	_____	_____
Stomach or bowel cancer	_____	_____	Polycystic ovaries	_____	_____
<u>Sexual activity</u>			Date of last period	_____	
Pain with sexual activity	_____	_____	Number of pregnancies	_____	
Difficulty with arousal or climax	_____	_____	Number of live deliveries _____		
Men – difficulty with erection	_____	_____	Number of miscarriages or abortions _____		

System Review

(Do you have a past or present history of any of the following?)

<u>Neurologic</u>	Past	Present	<u>Orthopedic</u>	Past	Present.
Recurrent headaches	_____	_____	Joint pain	_____	_____
Migraines	_____	_____	Joint swelling	_____	_____
Recurrent fainting	_____	_____	Bursitis	_____	_____
Loss of sensation	_____	_____	Arthritis (degenerative)	_____	_____
Muscle weakness	_____	_____	Rheumatoid arthritis	_____	_____
Stroke	_____	_____	Low back pain	_____	_____
Seizure history	_____	_____	Neck pain	_____	_____
Speech difficulty	_____	_____	Sciatica	_____	_____
Loss of memory (mild)	_____	_____	Disc problems	_____	_____
Loss of memory (severe)	_____	_____	Gout	_____	_____
Tingling or paresthesias	_____	_____	Tendonitis	_____	_____
Recurrent dizziness or vertigo	_____	_____	<u>Breast</u>		
Recurrent falling	_____	_____	Masses or lumps	_____	_____
<u>Emotional</u>			Tenderness	_____	_____
Depression	_____	_____	Abnormal mammogram	_____	_____
Psychiatric disorder	_____	_____	Biopsy	_____	_____
Bulemia/eating disorder	_____	_____	Cancer	_____	_____
Chronic sadness	_____	_____	Family history of cancer	_____	_____
Recurrent anxiety	_____	_____	Nipple discharge	_____	_____
Panic attacks	_____	_____	Swelling in armpit	_____	_____
<u>Immunologic/Infection</u>			<u>HematologyOncology</u>		
Recurrent illness	_____	_____	Easy bruising or bleeding	_____	_____
Chronic fatigue	_____	_____	Clotting abnormalities	_____	_____
HIV/AIDS	_____	_____	Cancer diagnosis	_____	_____
Recurrent fever or sweats	_____	_____	Swollen lymph nodes	_____	_____
Unintentional weight loss	_____	_____	Anemia	_____	_____