A/C# _________ **REAGAN MEDICAL CENTER, LLC** ADULT HEALTH QUESTIONAIRE (35 & UP)

Please take some time to fill this questionnaire as much as you can. This may help us prevent fatal diseases like Heart disease, Diabetes, Stroke, Bone Problems, etc. We hope that you will participate with this to ensure that we give you the best possible care.

I understand the benefits, risks and consequences of this questionnaire but sill do not wish to fill it out at this time. ______________________

_____________________	____________________________	______	M / F	__________
Signature	Name of the patient	Age	Sex	Date

FOR PATIENTS TO FILL OUT

Female Patients Only

Are you menopausal? Yes No

Any Family history of Breast Cancer? Yes No

Any Family history of Osteoporosis (weak bones)? Yes No

All Patients

Do you have any Shortness of Breath? Yes No

If yes: Is it at Rest or with how much Exertion? ____________

Do you have any Chest Pain? Yes No

Have you ever had any heart attack? Yes No

Have you ever passed out or felt Dizzy? Yes No

Do you get leg pains on walking? Yes No

Have you ever had swelling or pain in one/both legs? Yes No

Did you have sudden increase in your weight? Yes No

Have you ever had Stroke? Yes No

Do you have any varicose veins? Yes No

Do you have or had High Blood Pressure? Yes No

Do you have any Heart Problems? Yes No

Do you have abnormal gait or do you limp? Yes No

Do you get Tingling & Numbness in legs? Yes No

Do you ever have any visual problems? Yes No

Have you ever had Palpitations (Heart beating fast)? Yes No

Have you ever had chronic cough? Yes No

Do you have history of Asthma? Yes No

Do you ever hear wheezing from your lungs? Yes No

Do you have Diabetes? Yes No

Do you Smoke? Yes No

Do you have any cholesterol problems? Yes No

ANY FAMILY HISOTRY OF HEART PROBLEMS, HEART FAILURE, BLOOD PRESSURE, DIABETES OR ANY CANCERS?

How likely are you to fall asleep or doze in following situations? 0-Never 1-Slight chance 2-Moderate chance 3-High chance

1. Sitting and Reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting inactive in a public place (i.e. movie theatre)	0	1	2	3
4. As a passenger in a car	0	1	2	3
5. Lying to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

Total __________

1. Loud Snoring	Yes	No
2. Breathing or Snoring stops in my sleep	Yes	No
3. Awaken gasping for breath or snoring.	Yes	No
4. Any History of High Blood Pressure	Yes	No

Neck Circumference: ________________

TOTAL SCORE: ___________

Last Sleep Study done _____________________

FOR NURSES TO FILL OUT - Fill exact dates, please

Female Patients Only

Mammogram (>40yrs) __________ __________

Pap Smear (>17yrs) __________ __________

Annual Physical				
CBC				
Chem 14				
CRP				
Lipid Panel				
TSH				
Vit D level				
CXR				
EKG				
UA				
Hemmocult				
PSA *(men)*				
	Misc Labs			
ESR				
Hepatitis P.				
H.pylori				
Liver Panel				
Iron studies				
Vit B12				
Folic Acid				
Uric Acid				
	+Diabetes			
HbA1c				
Eye Exam				
	+ HTN			
U. microalb				
	Other			
Dexascan				
Carotid US				
Art. Dop				
Ven. Dop				
ABI				
CT				
MRI				
	Cardiac			
Echo				
Holter				
Nuclear ST				

FOR PROVIDERS TO REVIEW & SIGN & DATE

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