UZIMA
LIFESTYLE CENTER

Lifestyle History Forms Packet

DIRECTIONS

Herein you will find the Lifestyle History Forms to be completed as soon as possible, so that we can finalize your registration for the Lifestyle Program. These forms enable your first day with us to go smoothly. Please will you fill these forms out to the best of your ability and send them back to us via **email**.

If there are some things that don't apply to you, **please write so in the blank or check the boxes that say N/A or None**, so we know that you have not missed anything by accident.

Please be mindful to follow all of the instructions within the history forms as well, especially concerning the **family**, **diet**, and **lifestyle** sections.

The more details you fill out for us will ensure that we have not missed anything by the time you see the Providers on your first Monday with us. If you leave any blanks, or don't follow the directions above each section, we will need to call you for clarification prior to your arrival.

We kindly request that you also submit with this form a front and back copy (or photo) of your medical insurance card.

Thank you for your cooperation in this, and we look forward to having you here.

Clinic Staff

Email: uzimalifestylecenter@yahoo.com

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Medication List

Name: _____ **DOB:** ___/___/_____

Please list **all medication and supplements**, included the **dosage** of which one if possible, and the **type of doctor who prescribed** such as: primary care physician (PCP), OTC, self, specialist doctor (ex: eye doctor, heart doctor, etc.)

Please list any **allergies and reactions** to any medication/supplement, or indicate **none** if applicable:

_____

_____ ☐None

Date Begun	*Medication/ Supplement*	*Dosage (mg, mcg, UI)*	*Frequency*	*Who Prescribed? (PCP, OTC, Self, Specialist, etc.)*

Do you have any prescription medications for mental illness? No ☐ Yes ☐

If yes, please state the names and dosage: _____

_____

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Review of Systems

Have you had the following in the **last 6 months**? Check/circle 'yes' or 'no'.
If in doubt leave blank. No need of explanation.

Name: _____ DOB: __/__/__ Race: _____ Marital Status: _____
Nationality:_____ Religion: _____ Occupation: _____ Date:___/___/_____

GENERAL
Tire easily, weakness ..... yes no
Appetite down ..... yes no
Marked weight change ..... yes no
Night sweats ..... yes no
Persistent fever ..... yes no
Sensitivity to heat ..... yes no
Sensitivity to cold ..... yes no

SKIN
Eruptions (rash) ..... yes no
Acne ..... yes no
Change in color ..... yes no
Change in hair ..... yes no
Change in nails ..... yes no

EYES
Trouble seeing ..... yes no
Eye pain ..... yes no
Inflamed eyes ..... yes no
Double vision ..... yes no
Worn glasses ..... yes no

EARS
Loss of hearing ..... yes no
Ringing in the ears ..... yes no
Discharge ..... yes no

NOSE
Loss of smell ..... yes no
Frequent colds ..... yes no
Excess discharge ..... yes no
Nosebleeds ..... yes no

MOUTH
Sore gums ..... yes no
Soreness ..... yes no
Hoarseness ..... yes no

BREAST&GYN
Lumps ..... yes no
Discharge ..... yes no
Breast mass ..... yes no
Heavy, prolonged or irregular bleeding ..... yes no

CARDIO-RESPIRATORY SYSTEM
Persisting cough or sputum (phlegm) ..... yes no
Bloody sputum ..... yes no
Wheezing ..... yes no
Chest pain or discomfort ..... yes no
Pain on breathing ..... yes no
Shortness of breath ..... yes no
Difficulty breathing while lying down ..... yes no
Bluish fingers or lips ..... yes no
High blood pressure ..... yes no
Palpitations ..... yes no
Vein trouble ..... yes no

LYMPHATIC SYTEM
Enlarged lymph nodes ..... yes no
Location:_____
_____
(Please write location: neck, underarm, groin)

DIGESTIVE SYSTEM
Change in appetite ..... yes no
Heartburn ..... yes no
Nausea ..... yes no
Vomiting ..... yes no
Vomiting blood ..... yes no
Rectal bleeding ..... yes no
Black tar-like stools ..... yes no
Dark urine ..... yes no
Jaundice ..... yes no
Constipation ..... yes no
Diarrhea ..... yes no
Hemorrhoids ..... yes no
Need for laxatives ..... yes no

GENITOURINARY SYSTEM
Increase in frequency of urination (day) ..... yes no
Increase in frequency of urination (night) ..... yes no
Feel need to urinate without much urine ..... yes no
Unable to hold urine ..... yes no
Blood in urine ..... yes no
Albuminuria ..... yes no
Impotence ..... yes no
Pain with intercourse ..... yes no

ENDOCRINE
Change in sensation ..... yes no
Memory loss ..... yes no
Poor coordination ..... yes no
Weakness or paralysis ..... yes no
Thyroid trouble ..... yes no
Cortisone treatment ..... yes no
Diabetes ..... yes no

LOCOMOTOR
Muscle cramps ..... yes no
Muscle weakness ..... yes no
Pain in the joints ..... yes no
Swollen joints ..... yes no
Stiffness ..... yes no
Back pain ..... yes no
Osteoporosis ..... yes no
Osteoarthritis ..... yes no
Rheumatoid Arthritis ..... yes no
Deformity of joints ..... yes no

NEUROLOGIC
Headaches ..... yes no
Dizziness ..... yes no
Fainting ..... yes no
Convulsion or fits ..... yes no
Nervousness ..... yes no
Numbness ..... yes no
Sleeplessness ..... yes no

PSYCHIATRIC
Depression ..... yes no
Grieving ..... yes no
Anxiety ..... yes no

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Please fill this form out to the best of your ability and send it back to us via FAX or EMAIL. If there are some things that don't apply to you, please check the None or N/A box for each section, or write it in the blank space, so we know that you have not accidentally missed anything.

Name: _____ **Date:** ____/____/____

Chief Complaint(s):

_____

_____

_____

Diagnosed Problem(s)/Condition(s) - (please indicate what and date of diagnosis):

_____

_____

_____

PAST MEDICAL HISTORY

Allergies & Reaction (medications, foods, seasonal, pets, etc.):

_____

_____ ☐None

Serious Illness or Accidents (date of occurrence, complications):

_____

_____

_____

_____ ☐N/A

Surgeries (date, diagnosis/surgery, complications):

_____

_____

_____ ☐N/A

Have you ever had a test for the heart (when/type/result)? _____

_____ ☐N/A

Have you ever been diagnosed with an unexplained seizure disorder? _____ ☐N/A

Recent Travel Outside of U.S. (where/when): _____ ☐N/A

Transfusion/Dates: _____ ☐N/A

Last Colonoscopy/Result: _____ ☐N/A

Last DEXA (Bone Density Scan)/Result: _____ ☐N/A

Female Only:

OB-GYN History:

Contraception used: _____ ☐N/A

Date/Result of Last Pap-Smear and Pelvic exam: _____ ☐N/A

Date/Result of last Mammogram: _____ ☐N/A

Number of pregnancies (indicate if miscarriage): _____ ☐N/A

Natural or C-section delivery? _____ ☐N/A

Presence of menstrual pain: _____ If in menopause/date begun: _____ ☐N/A

Male Only:

Urologic History: Results and dates of last Prostatic exams (digital/ultrasound/PSA):

_____

_____ ☐N/A

FAMILY HISTORY:

Please indicate whether your parents/siblings are alive or not by checking in the correct space, as well as their current age and any health issues. Please also indicate age at death, as well as the cause, and any other additional health issues they had. Check "None" if family member has no known health complication.

	Living	Deceased	Age	Death's Cause	Health Issues
Father	☐	☐			☐None
Mother	☐	☐			☐None
Brothers	☐	☐			☐None
	☐	☐			☐None
Sisters	☐	☐			☐None
	☐	☐			☐None

Please indicate whether or not other relatives have any health conditions or not, such as cancer (type), diabetes (type), high blood pressure, high cholesterol, arthritis, autoimmune, etc. If unknown, check box.

Relatives (aunts, uncles, grandparents, etc.) (ages, health issues and/or death's causes):
Paternal: _____

_____

_____ **☐Unknown**

Maternal: _____

_____

_____ **☐Unknown**

SOCIAL HISTORY:

Marital Status: ☐S ☐M ☐D ☐W; **Present number of marriages** _____(if previously divorced)

Home environment: ☐Happy ☐Stressful; **No. of Children** _____; **Caring for relatives/friends:** ☐Yes ☐No
Occupation: _____ **Occupation of spouse:** _____

Work environment: ☐Happy ☐Hazardous ☐Stressful ☐Other_____
Hobbies: _____

Religious affiliation _____ **Regular church attendance:** ☐Yes ☐No
Are you under more stress than usual/why? _____

_____

_____ **☐N/A**

DIET:
Please fill out all fields with as much detail as possible.

Type of diet (omnivorous/vegetarian/vegan): _____

Meals per day: ☐1 ☐2 ☐3 ☐Other:_____ **Biggest Meal:** ☐Breakfast ☐Lunch ☐Supper

General Description of meals (Breakfast, Lunch, Supper/Dinner):
Time: _____ B: _____

_____

Time: _____ L: _____

_____

Time: _____ S: _____

_____

Please check the box if you are presently eating the following, and indicate frequency, as well as type of food/product used.

FOOD TYPES	If yes, check	FREQUENCY (how often per week/day) & TYPE USED:
Dairy (milk, cheese, yogurt, etc.?)	☐	
Meat (red meat, chicken, fish?)	☐	
Eggs	☐	
Fruit (fresh, canned, frozen?)	☐	
Vegetables (fresh, canned, frozen?)	☐	
Caffeine (coffee, soda, black/green teas, chocolate?)	☐	
Sweets (homemade, processed?)	☐	
Snacks (what, frequency, time?)	☐	

LIFESTYLE:
Please check the box if you have used any of the following, and explain:

TYPE	YES	NO	
Alcohol Intake	☐	☐	How long used: _____ Amount: _____ Frequency: _____ Last time consumed: _____
Tobacco Use	☐	☐	How long used: _____ Smoke/Chew: _____ Packs per day: _____ Last time consumed: _____
Illicit Drug Abuse	☐	☐	How long used: _____ Type: _____ Last time consumed: _____
Prescription medication: Have you ever taken more than the doctor prescribed?	☐	☐	**Explain:** _____ _____

Sleep:
How much sleep do you get per night? _____
What time do you usually go to sleep? _____
Do you have insomnia or trouble falling asleep? _____
Do you use sleeping aids/pills to help you sleep? _____
Do you have any habits before going to bed? _____
Is your sleep interrupted? If so, why? _____
_____

Exercise:
How often do you exercise per week? _____
How long do you exercise? _____
Is your exercise indoor or outdoor? _____
What kind of exercise do you do? _____
Have you ever fainted/passed out during or after exercise? _____
Have you ever had extreme or unusual fatigue associated with exercise? _____
Have you ever had extreme shortness of breath during exercise? _____
Have you ever had chest discomfort, pain, or pressure during exercise? _____
Have you ever been diagnosed with exercise induced asthma? _____

How many ounces of water do you drink per day? _____

Adult Well-being

Today's Date: _____ Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
4. Not being able to stop or control worrying	☐	☐	☐	☐

Has there ever been a period of time when you were not your usual self and…	No	Yes
5. …you felt so good or full of energy that other people thought you were not your normal self or it got you into trouble? (e.g., unable to sleep, over-spending, gambling)	☐	☐
6. …if you were so irritable that you shouted at people or started fights or arguments?	☐	☐

During the past year:	No	Yes
7. Have you ever had 4 or more drinks (women) / 5 or more drinks (men) in a day?	☐	☐
8. Have you used an illegal drug or used a prescription drug for a non-medical reason?	☐	☐

Over the last 4 weeks:	No	Yes
9. Have you had a problem with sleep more than occasionally? (This could include: trouble falling asleep, waking frequently, or sleeping too much.)	☐	☐

DAILY ACTIVITIES
10. How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health?
☐ No difficulty at all ☐ A little bit of difficulty ☐ Some difficulty ☐ Much difficult ☐ Could not do
SOCIAL ACTIVITIES
11. Has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely
OVERALL HEALTH
12. How would you rate your health in general?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor