South Denver Internal Medicine
A Concierge Medical Practice
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ANNUAL PREVENTIVE HEALTH HISTORY

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Name: Date:

Do you have any current health concerns?

1. NUTRITION

Do you follow a special diet?	Yes ☐	No ☐	Describe:
What do you typically eat for breakfast?			
What do you typically eat for lunch?			
What do you typically eat for dinner?			
Do you typically drink 5-8 glasses of water per day?	Yes ☐	No ☐	
Do you typically snack during the day?	Yes ☐	No ☐	Describe your snacks:
How would you describe your portion sizes?	Small ☐	Medium ☐	Large ☐ Other:
Indicate how many servings of fruits *and* vegetables you have per day?			**One Serving= 1 cup green leafy vegetable or ½ cup raw or cooked vegetable or ¼ cup dried fruit or 1 small piece fruit or ½ cup chopped fruit.**

2. EXERCISE

Do you exercise regularly?	Yes ☐	No ☐	If you answered "No" please indicate why?			
Do you perform cardiovascular exercises?	Yes ☐	No ☐	Walking ☐	Treadmill ☐	Elliptical ☐	Bicycle ☐
			Running ☐	Yoga ☐	Other:	
Do you perform strength training exercises?	Yes ☐	No ☐	Weights ☐	Yoga ☐	Pilates ☐	Other:
Do you perform stretching, flexibility or balance training exercises?	Yes ☐	No ☐				
How many minutes do you exercise per session?	10 minutes ☐	20 minutes ☐	30 minutes ☐	40 minutes ☐		
	50 minutes ☐	60 minutes ☐	> 60 minutes ☐			
How many days per week do you exercise?	1 day ☐	2 days ☐	3 days ☐	4 days ☐		
	5 days ☐	6 days ☐	7 days ☐			

Patient Name:

3. SLEEP

How many hours do you sleep?						
How long does it typically take you to fall asleep?	<15 min ☐	20 min ☐	30 min ☐	45 min ☐	60 min ☐	>60 min ☐

Question	Yes	No	
Do you take anything to help you sleep?	Yes ☐	No ☐	Describe what you take?
Do you typically wake up in the middle of the night?	Yes ☐	No ☐	Describe why?
Do you typically go right back to sleep after you wake up?	Yes ☐	No ☐	Describe why you may not?
Do you snore?	Yes ☐	No ☐	
Do you typically wake up tired?	Yes ☐	No ☐	
Do you take naps during the day?	Yes ☐	No ☐	What time of the day and for how long?

4. EMOTIONAL HEALTH

Question	Yes	No	
Do you or have you recently felt depressed?	Yes ☐	No ☐	Describe:
Do you or have you recently felt anxious?	Yes ☐	No ☐	Describe:
Do you have any major stressors in your life?	Yes ☐	No ☐	Describe:

5. VACCINATIONS: Have you received any NEW vaccines in the PAST YEAR?

Vaccine	Date last given	Vaccine	Date last given
COVID-19: Brand:		Prevnar 13 (Pneumonia)	
Influenza:		Shingrix (Shingles)	
Pneumovax (Pneumonia)		Tetanus (Td or Tdap)	

6. HEALTH SCREENING: Have you received any health screenings in the LAST YEAR?

Test	Date last performed	Test	Date last performed
Calcium Heart Score		Prostate Exam (men only)	
Colonoscopy		Bone Density (women only)	
Dental Exam		Mammogram (women only)	
Dermatology Skin Cancer Exam		Pap smear (women only)	
Eye Exam		Breast Exam (women only)	

7. RISK FACTORS

Question	Yes	No	
Do you drink alcohol?	Yes ☐	No ☐	How many drinks/week?
Do you drink caffeine?	Yes ☐	No ☐	How many cups/day?
Do you use tobacco products?	Yes ☐	No ☐	Describe:
Do you drink sugary soft drinks?	Yes ☐	No ☐	How many/week?

Patient Name:

Mark if you CURRENTLY have or recently have had any of the following symptoms.

GENERAL

- [ ] Abnormal bleeding
- [ ] Abnormal bruising
- [ ] Chills
- [ ] Cold intolerance
- [ ] Dizziness
- [ ] Fainting episodes
- [ ] Fatigue
- [ ] Fever
- [ ] Flushing
- [ ] Heat intolerance
- [ ] Loss of appetite
- [ ] Lymph node large
- [ ] Night sweats
- [ ] Sleep disturbance
- [ ] Thirst excessive
- [ ] Weight gain
- [ ] Weight loss

EYES

- [ ] Blurry vision
- [ ] Double vision
- [ ] Dry Eyes
- [ ] Eye discharge
- [ ] Eye pain
- [ ] Floaters
- [ ] Light sensitivity
- [ ] Vision loss

EARS, NOSE & THROAT

- [ ] Bleeding gums
- [ ] Earache
- [ ] Ear discharge
- [ ] Hearing loss
- [ ] Hoarseness
- [ ] Nasal congestion
- [ ] Nosebleeds
- [ ] Ringing ears
- [ ] Seasonal allergies
- [ ] Sore throat
- [ ] Vertigo

HEART

- [ ] Chest discomfort
- [ ] Chest pain
- [ ] Difficulty breathing @ night
- [ ] Exercise intolerance
- [ ] Leg cramps exercise
- [ ] Palpitations/racing heart
- [ ] Short of breath exercise
- [ ] Swelling (legs or feet)

LUNGS

- [ ] Breathing problems
- [ ] Cough
- [ ] Coughing up blood
- [ ] Short of breath
- [ ] Snoring
- [ ] Sputum
- [ ] Wheezing

GASTROINTESTINAL

- [ ] Abdominal pain
- [ ] Black tarry stools
- [ ] Bloating
- [ ] Bloody stools
- [ ] Change in bowel habits
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive gas
- [ ] Heartburn & indigestion
- [ ] Hemorrhoids
- [ ] Nausea
- [ ] Swallowing difficulty
- [ ] Swallowing pain
- [ ] Vomiting
- [ ] Vomiting blood

ENDOCRINE

- [ ] Skin color has changed
- [ ] Sweating., excessive
- [ ] Thirst, excessive
- [ ] Unusual hair distribution

URINARY

- [ ] Blood in urine
- [ ] Inability to control bladder
- [ ] Inability to empty bladder
- [ ] Frequent urination
- [ ] Genital sores
- [ ] Lack of sexual drive
- [ ] Nighttime urination
- [ ] Painful urination
- [ ] Urinary urgency
- [ ] Weak urinary stream

MUSLCES AND JOINTS

- [ ] Back pain
- [ ] Joint pain
- [ ] Joint swelling
- [ ] Morning stiffness
- [ ] Muscle cramps
- [ ] Muscle weakness

SKIN

- [ ] Change in moles
- [ ] Excessive dry skin
- [ ] Hair loss
- [ ] Hives
- [ ] Itching
- [ ] Nail changes
- [ ] Rash
- [ ] Skin cancer
- [ ] Sores non-healing

NEUROLOGY

- [ ] Concentration difficulty
- [ ] Falling down
- [ ] Headaches
- [ ] Numbness or tingling
- [ ] Paralysis
- [ ] Poor balance
- [ ] Seizures
- [ ] Tremors
- [ ] Weakness

PSYCHIATRY

- [ ] Anxiety
- [ ] Depression
- [ ] Hallucinations
- [ ] Suicidal thoughts
- [ ] Violent thoughts

MEN ONLY

- [ ] Erection problems
- [ ] Lump in testicle
- [ ] Penis discharge
- [ ] Sore on penis

WOMEN ONLY

- [ ] Abnormal PAP
- [ ] Breast lump
- [ ] Breast pain
- [ ] Heavy bleeding
- [ ] Hot flashes
- [ ] Irregular periods
- [ ] Nipple discharge
- [ ] Painful intercourse
- [ ] Painful periods
- [ ] Vaginal discharge
- [ ] Vaginal itching
- [ ] Vaginal sores