BaySport

Health History Survey

Welcome to BaySport.

Please take a few moments to complete the following health history survey. Should you have any questions regarding this survey, do not hesitate to ask a BaySport team member.

To view BaySport's patient privacy notice, please click here.

www.BaySport.com

IDENTIFICATION

Today's Date: ___________________

Name: ____
Last First Middle

Home Address: ____

City/State/Zip:_ ____

Home or Cell Phone: ____

E-Mail (for medically-related correspondence): _______________________________________

Date of Birth ____/____/____ Sex __________ Age ______________

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widow/Widower ❒ Other

Company: ____Badge/ID No. _________________________

Title: ____

Business Address: ____

City/State/Zip: ____

Business Telephone: ____________________________E-Mail: ___________________________________

Emergency Contact:

Name:____
Last First Middle

Telephone: (Work)____________________(Home)____________________Relationship: ______________

Personal Physician:

Name: ____ Telephone: ____________________________

Address: ____City/State/Zip: ___________________________

In an effort to be more environmentally-conscious, BaySport's goal is to minimize printing materials. You may now receive your results electronically on a USB/jump drive or in the standard paper form.

I prefer receiving the results of my exam in:

❒ Electronic Form (PDF) ❒ Paper Form ❒ Both Electronic and Paper

____

PERSONAL MEDICAL HISTORY

Have you been treated for any of the following?

Yes	No	
❒	❒	Heart attack, cardiovascular surgery, stroke or chest discomfort with exertion?
❒	❒	High blood pressure (>140/90)? If yes, is it controlled with medication? ______________
❒	❒	Cholesterol abnormality? If yes, is it controlled with medication? ___________________
❒	❒	Enlarged heart or congestive heart failure?
❒	❒	Heart murmur or rheumatic fever?
❒	❒	Electrocardiogram abnormality, heart block or irregular rhythm?
❒	❒	Diabetes mellitus? If yes, is it controlled with medication? _________________________
❒	❒	Black outs or loss of consciousness?
❒	❒	Shortness of breath or difficulty breathing?
❒	❒	Positive test for a blood borne pathogen (i.e. hepatitis, HIV, etc.)?

If you answered yes to any of these questions, please explain when the event or diagnosis occurred and what was done, if anything, to resolve the issue.

____

____

Please list any other serious medical problems or injuries (include date of event).

____

____

Surgical procedures and/or hospitalizations (include date of event):

____

____

Are you currently being treated for any medical condition?

____

____

Current medications or dietary supplements (include dosage and frequency):

____

____

Known allergies (foods, medications, environmental):

____

____

Please indicate the year and result, if you have had any of the following procedures:

Procedure	Year	Result		
❐ Bone Density	____________	❐ Normal	❐ Abnormal	____________
❐ Cardiac Stress Test	____________	❐ Normal	❐ Abnormal	____________
❐ Chest X-Ray	____________	❐ Normal	❐ Abnormal	____________
❐ Colonoscopy	____________	❐ Normal	❐ Abnormal	____________
❐ Echocardiogram	____________	❐ Normal	❐ Abnormal	____________
❐ Mammogram	____________	❐ Normal	❐ Abnormal	____________
❐ Vascular Screening	____________	❐ Normal	❐ Abnormal	____________
❐ Tuberculin Skin Test	____________	❐ Normal	❐ Abnormal	____________
❐ ______________ Other (please specify)	____________	❐ Normal	❐ Abnormal	____________

Immunization Status: Have you had any of the following immunizations?

	Yes	No	Don't Know	Year (If yes, please indicate the year)
Tetanus/diphtheria/pertusis in the past 10 years (TDAP, Td)	❐	❐	❐	________
Measles, mumps and rubella (MMR)	❐	❐	❐	________
Hepatitis A (2 shots)	❐	❐	❐	________
Hepatitis B (3 shots)	❐	❐	❐	________
Varicella (chickenpox) vaccine or had chickenpox	❐	❐	❐	________
Shingles (Zostavax) vaccine	❐	❐	❐	________
Influenza (flu)	❐	❐	❐	________
Other______________________________	❐	❐	❐	________

If available, please bring a copy of your immunization records to your appointment

Men's Health

When was your last prostate/PSA exam? ____________(Year) ❐ Never ❐ Don't Know

How often do you examine your testicles? ❐ Monthly ❐ Every few months ❐ Rarely

Have you ever had any difficulties getting or maintaining an erection? ❐ Yes ❐ No

Women's Health

When was your last PAP exam? ______________(Year) ❐ Never ❐ Don't Know

How often do you examine your breasts? ❐ Monthly ❐ Every few months ❐ Rarely

Date of your last period? ____________________________

FAMILY HISTORY: Please indicate which family members have had the following:

Condition	Mother	Father	Grandmother	Grandfather	Sister	Brother	Other
Alcoholism	❒	❒	❒	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	❒	❒	❒
If yes, please specify type: ___							
Colon Polyps	❒	❒	❒	❒	❒	❒	❒
Depression	❒	❒	❒	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	❒	❒	❒
Glaucoma	❒	❒	❒	❒	❒	❒	❒
Heart Disease	❒	❒	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒	❒	❒
High Cholesterol	❒	❒	❒	❒	❒	❒	❒
Osteoporosis	❒	❒	❒	❒	❒	❒	❒
Stroke	❒	❒	❒	❒	❒	❒	❒
Tuberculosis	❒	❒	❒	❒	❒	❒	❒
Thyroid disorder	❒	❒	❒	❒	❒	❒	❒
Respiratory Disorder	❒	❒	❒	❒	❒	❒	❒

Please list any other significant family medical conditions:

____

____

For each member of your immediate family, please list age and health status:

Father: Age__________ Health Status____________________

Mother: Age__________ Health Status____________________

Brother(s): Age(s)__________ Health Status____________________

Sister(s): Age(s)__________ Health Status____________________

Children: Age(s)__________ Health Status____________________

PHYSICAL ACTIVITY:

List all typical exercise or sports-related activities:
(Aerobic, Strength, Flexibility, Sports and Recreational Activities)

Current Activity	# Days/Week	Minutes/Session
____________	______	______
____________	______	______
____________	______	______
____________	______	______

____

DIETARY HISTORY

Rank your diet on a scale from 1 to 5: ______________________
(1 – Excellent, 2 – Good, 3 – Average, 4 – Fair, 5 – Poor)

How many servings of vegetables do you eat in an average day?
(1 serving = 1 medium size veggie (carrot, bell pepper, tomato), 10 baby carrots, 1 cup salad greens, ½ cup cooked vegetables)

❒ 0-1 serving ❒ 1-3 servings ❒ 3-5 servings ❒ >5 servings

How many servings of fruits do you eat in an average day?
(1 serving = 1 medium sized fruit (apple/orange/banana/peach), 2 small fruits (plum/apricot), ½ large fruit (grapefruit), 15 grapes, ¼ cup dried fruit)

❒ 0-1 serving ❒ 1-3 servings ❒ 3-5 servings ❒ >5 servings

How many servings of soluble fiber foods do you eat per day?
(1 serving = 1 medium apple/pear/orange, ½ cup mixed berries, ½ cup uncooked oatmeal, ¼ cup oatbran, ½ cup of beans/lentils/peas)

❒ 0-1 servings ❒ 1-2 servings ❒ 2-3 servings ❒ >3 servings

Do you tend to eat more refined grain products, whole grain, or sprouted grain products?
(Refined Grains: crackers, instant/white rice, most breads, rolls, pasta, regular breakfast cereals) (Whole Grains: oatmeal, barley, whole grain cereals, breads, and pasta, brown/mixed grain rice, sprouted grain)

❒ Mostly Sprouted Grain ❒ Mostly Whole Grain ❒ ½ Whole / ½ Refined ❒ Mostly Refined Grain

How many meals/day do you eat on average? Mon-Fri ____________ Sat/Sun______________

How many snacks/day do you eat on average? Mon-Fri ____________ Sat/Sun______________

How many sweetened beverages do you consume on an average day? __________________________
(non-diet soda, sweetened tea beverages, flavored coffee drinks, fruit juice)

How many servings of artificial sweeteners or products with artificial sweeteners do you consume on an average day (Splenda, Equal, Sweet'n Low)? __________________________________

How many servings of fatty fish (salmon, sardines) and/or Omega-3 fatty acids (fish, krill or cod liver oil, flax seeds, walnuts, soybeans, greens, etc.) do you consume each day? __________

How many alcoholic drinks do you consume on average? ______________________________
(1 drink = 12 oz beer, 1.5 oz liquor, 5 oz wine)

Monday - Friday ____________ average drinks/day

Saturday and Sunday ____________ average drinks/day

HEALTH HABITS

Do you currently smoke cigarettes? ❒ Yes ❒ No

If yes, how many per day? _____________for how many years? _______________

If not a current smoker, did you ever smoke cigarettes? ❒ Yes ❒ No

If yes, when did you quit? ___________ How many per day? ______ For how many years? _________

Do you smoke cigars, a pipe or use smokeless tobacco? ❒ Yes ❒ No

If yes, what? _____________________ how much per day? ________________________

Average number of days per month of domestic travel? ________________

Average number of days per month of international travel? _________________

What countries? ____

Do you ever use any medications to aid your sleep? ❒ Yes ❒ No

How many hours, on average, do you sleep each night? _______________________________

Do you snore? ❒ Yes ❒ No

Is your weight a concern to you? ❒ Yes ❒ No

(If yes, what do you regard as your ideal weight? _______________ lbs.)

What are your goals and objectives for participating in this program?

____

____

Please list any concerns you wish to discuss with the doctor:

____

____

The information provided in this questionnaire is accurate to the best of my knowledge.

____

Signature

____