BaySport
Health History Survey

Welcome to BaySport.

Please take a few moments to print, complete and bring to your appointment the following health history survey. Should you have any questions, 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

_____