Wellness and prevention have always been a priority at the Center for Integrative Medicine. Optimal health is achieved by following basic principles of wellness and working with your primary care team to ensure proper preventive measures are tracked. The Wellness Evaluation will be an updating and improvement on the ñannual physicalò geared toward helping you achieve optimal health.

The annual physical has most commonly been thought of as a time to see the doctor for a head-to-toe physical exam and to discuss any aches, pains, problems or concerns. Unfortunately, this format has never been proven to extend life or prevent disease. On the contrary, it often serves to distract the physician from covering in detail the important issues of lifestyle choice and proven preventive screening and testing.

A complete Wellness Evaluation will include:

1) Identifying risk factors in your personal and family medical history that put you at risk for early disease and death.
2) Performing a focused exam, as appropriate.
3) Obtaining needed preventive screening tests at the proper intervals.
4) Encouraging you to choose healthy lifestyles to maximize your health and providing tools to accomplish your goals.

The questionnaire that you have received will help us to achieve these goals.

Unfortunately, we will not have adequate time to address medical problems that we may identify at this visit. However, we will be able to initiate any appropriate work-up and schedule a follow-up visit so we can adequately address your concerns and problems. If you do have concerns that need immediate attention, please alert the front desk staff so we may change the focus of this appointment to better serve you.

We will need to have an open and honest discussion about lifestyle choices and about the controversies in preventive screening, such as mammograms in women between ages 40 ï 50 and prostate cancer screening in men. Therefore, we encourage you to ask questions and take a partnership approach with our providers. After all, it is your health, and it is our job and duty to help you keep and enjoy it.

Finally, we will want to provide you with a plan for optimizing your health. This will include general information and advice about healthy living including diet, exercise, sleep and stress reduction. We will also recommend specific screening tests to help prevent and detect disease before it negatively impacts your life. We will be using guidelines from the United States Preventive Medicine Task Force for guidance, and we will want to discuss controversies where they exist in these recommendations. We at the Center for Integrative Medicine are excited to help you on your health journey, and our hope is that the Wellness Evaluation will be an important part in helping you to achieve and maintain optimal health.

Health Maintenance Evaluation
Men Age 40 to 64

1. Age: _____
2. Past Medical History
   A. Have there been any significant changes in your medical history or surgeries since your last health maintenance exam or since you established your care here?
      Ĭ yes Ĭ no
   B. For Provider: update problem/surgery list
      _____
      _____
      _____
3. Family History
   A. Has there been any change in your family history since your last health maintenance exam or since you established you care here?
   B. For Provider: update family history
      _____
      _____

4. Sexual Health
   A. Are you sexually active? Ĭ yes Ĭ no
   B. Sexual preference? Ĭ men Ĭ women Ĭ both
   C. Do you have any history of STDôs? Ĭ yes Ĭ no
      1. Please list. _____
   D. Number of sexual partners in the last 12 months. _____

5. Tobacco Use
   A. Have you ever used tobacco? Ĭ yes Ĭ no
   B. Average packs/cans per day. _____
   C. Number years of use. _____
   D. Year quit. _____
   E. When are you planning to quit?
      Ĭ now Ĭ next 6 months Ĭ sometime Ĭ never

6. Prevention
   A. Do you have any concerns about your weight? Ĭ yes Ĭ no
   B. What is your goal weight? _____
   C. Who is responsible for your food shopping? _____
   D. Who does the cooking? _____
   E. Check how many of each type of food you eat and how many times each week
      Ĭ Home cooked meal _____
      Ĭ Heat and serve meal _____
      Ĭ Fast food _____
      Ĭ Restaurant _____
      Ĭ Take out _____
      (Grocery or restaurant)

F. Exercise

1. Activities: _____
2. Days per week: _____
3. Time/Duration: _____
4. Exertion: Ĭ easy (stroll) Ĭ moderate Ĭ heavy

G. Have you had a tetanus shot in the past 10 years? Ĭ yes Ĭ no date _____

H. Last dental exam? _____

I. Do you have any tattoos? Ĭ yes Ĭ no

J. Do you have any hearing problems? Ĭ yes Ĭ no

7. Sleep

A. How many hours of sleep do you get on average? _____

B. Do you have trouble falling asleep? Ĭ yes Ĭ no

1. How many nights a week? _____
2. How long on average does it take you to fall asleep? _____

C. Do you wake frequently at night? Ĭ yes Ĭ no

1. How many times a night? _____
2. Trouble falling back to sleep? Ĭ yes Ĭ no

D. Do you snore? Ĭ yes Ĭ no

E. Do you stop breathing in your sleep? Ĭ yes Ĭ no

F. Are you excessively sleepy in the day? Ĭ yes Ĭ no

8. Emotional Health

A. In past 2 weeks, have you been bothered by:

a. Little interest or pleasure in doing things? Ĭ yes Ĭ no
b. Feeling down, depressed or hopeless? Ĭ yes Ĭ no

9. Alcohol Use

a. Please complete the form on the following page.

1. How often do you have a drink containing alcohol? (0) Never (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7.8. or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year