DETAILED HEALTH ASSESSMENT

Client Name: _____

Date of Birth: _____ Gender: _____

GENERAL HEALTH INFORMATION

1. Height: _____ Weight: _____
2. Any weight change in the past 12 months? ☐ Yes ☐ No Details: _____
3. Blood pressure: _____ Cholesterol/HDL: _____ Date of last reading: _____
4. List current medications and dosages:
   a. _____
   b. _____
   c. _____
   d. _____

Family history

Has any family member had cancer, diabetes, high blood pressure, heart disease, or kidney disease prior to age 60? If yes, please supply the information requested in the following table:

Realtionship to you	Diagnosis	Age of onset	If deceased, age at death
1.			
2.			
3.			
4.			

Tobacco/nicotine use

1. Have you ever smoked cigarettes? ☐ Yes ☐ No
   a. If yes, date of last cigarette: _____

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2. Do you use an alternate form of tobacco? ☐ Yes ☐ No

   a. If yes, how often/how many?

   Cigars: _____

   Pipes: _____

   Chewing tobacco: _____

   Nicotine gum/patch: _____

   Other: _____

IMPAIRMENT HISTORY

Cancer ☐ Yes ☐ No

1. Type: _____ Location: _____ Stage and grade: _____
2. Date of diagnosis: _____ Last date of treatment: _____
3. How was the cancer treated? (Check all that apply.):

☐ Surgery ☐ Chemotherapy ☐ Radiation therapy

☐ Hormonal therapy ☐ Immunotherapy ☐ Other: _____

Specific cancer: additional information

Breast cancer

1. How was the cancer treated?

☐ Removal of tumor only ☐ Lumpectomy or wide excision

☐ Mastectomy ☐ Radiation ☐ Chemotherapy

☐ Hormones ☐ Other: _____

2. Were lymph nodes involved? ☐ Yes ☐ No

   a. If yes, how many were involved? _____

3. Date and result of last mammogram: _____

Lymphoma

1. Type of lymphoma:

☐ Hodgkin's lymphoma

☐ Non-Hodgkin's lymphoma, low grade

☐ Non-Hodgkin's lymphoma, intermediate grade

☐ Non-Hodgkin's lymphoma, high grade

2. Please indicate whether any of the following were present at the time of diagnosis. (Check all that apply.):
   - ☐ Type B symptoms (e.g., fever, weight loss, night sweats)
   - ☐ Large mediastinal (chest) disease (i.e., tumor > 7.50 cm.)
   - ☐ Elevated LDH (blood test)
   - ☐ More than one extranodal site involved

Prostate cancer

1. How was the cancer treated?
   - ☐ Observation only
   - ☐ TURP (transurethral prostatectomy)
   - ☐ Radical prostatectomy
   - ☐ Radiation (seed implant or external beam radiation)
   - ☐ Hormones
   - ☐ Other: _____
2. What was the Gleason score? _____
3. Date of most recent PSA test: _____ Results: _____
4. PSA level prior to treatment: _____

Skin cancer

1. What type of skin cancer?
   ☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Malignant melanoma
2. If malignant melanoma only:
   a. Where located? _____
   b. Any evidence of recurrence? _____
   Stage: _____ Ulcerated: ☐ Yes ☐ No
   Clark's level: _____ Thickness (in mm): _____
   Any positive lymph node(s)? ☐ Yes ☐ No

Ovarian cancer

1. Date of most recent CA 125: _____ Results: _____

Cardiac disorders ☐ Yes ☐ No

General questions

1. Date of last visit to cardiologist: _____
2. Date of most recent stress test: _____ Results: _____
3. Date of most recent echocardiogram: _____ Results: _____
4. Date of most recent electrocardiogram (EKG): _____ Results: _____
5. Do you carry nitroglycerin? _____ Date of last usage: _____

6. Do you currently have any symptoms of:

☐ Chest pain ☐ Dizziness

☐ Blackouts ☐ Shortness of breath

☐ Palpitations ☐ Chest discomfort

Any history of:

1. Atrial fibrillation? ☐ Yes ☐ No

   a. If yes, date of onset: _____

   b. Is the atrial fibrillation/flutter? ☐ Chronic ☐ Paroxysmal

   c. The cause of the atrial fibrillation/flutter is:

   ☐ Coronary heart disease ☐ Thyroid disease

   ☐ Mitral valve disease ☐ Alcohol

   ☐ Cardiomyopathy ☐ Other: _____

2. Mitral valve prolapsed? ☐ Yes ☐ No

   a. If yes, date of onset: _____

   b. Treatment given: _____

3. Myocardial infarction (i.e., heart attack)? ☐ Yes ☐ No

   a. Have you had any of the following?

Vessels	Date	Results	# of
Coronary catherization			
Coronary artery bypass graft			
Angioplasty			
Heart failure			
Arrhythmias			

   b. Do you have any of the following?

   ☐ Abnormal lipids levels ☐ Diabetes

   ☐ Overweight ☐ Elevated homocysteine level

   ☐ High blood pressure ☐ Peripheral vascular disease

   ☐ Irregular heart beat ☐ Cerebrovascular or carotid disease

4. Valvular heart surgery? ☐ Yes ☐ No
   a. If yes, date of surgery: _____
   b. Type of valve surgery:
      If valve replacement, which valve? _____
      If valvuloplasty, which valve? _____
      Commissurotomy? ☐ Yes ☐ No
      Other: _____
   c. Type of valve disorder:
      ☐ Aortic stenosis ☐ Mitral stenosis
      ☐ Aortic insufficiency ☐ Mitral insufficiency
      ☐ Mitral valve prolapse
5. Hypertension? ☐ Yes ☐ No
   a. If yes, date of diagnosis: _____
   b. What was the most recent blood pressure reading? _____ Date: _____
   c. Other impairments? _____

Diabetes ☐ Yes ☐ No

1. Date of diagnoses: _____
2. How often do you visit your physician? _____
   a. Date of last visit: _____
3. How is the diabetes controlled?
   ☐ Diet alone
   ☐ Oral medications Medications and dosages: _____
   ☐ Insulin Unit amount/times per day: _____
4. Your most recent blood sugar reading: _____
5. Do you monitor your own blood sugar? ☐ Yes ☐ No
6. Most recent glycohemoglobin (HbA1c) or fructosamine level: _____
7. Do you suffer from the following?
   ☐ Kidney disease ☐ Overweight
   ☐ Protein in the urine ☐ Neuropathy
   ☐ Retinopathy ☐ Other: _____

COPD/asthma ☐ Yes ☐ No

1. Type of lung disease:
   - ☐ Chronic bronchitis ☐ Emphysema
   - ☐ Restrictive lung disease ☐ Asthma
2. Date of diagnosis: _____
3. Have you ever been hospitalized? ☐ Yes ☐ No
   a. If yes, when and why? _____
4. Have you ever smoked cigarettes?
   - ☐ Yes, currently smokes Amount per day: _____
   - ☐ Yes, but quit Date quit: _____
   - ☐ No
5. Has a pulmonary function test ever been done? ☐ Yes ☐ No
   a. If yes, date and results: _____
6. Are you on inhalers? ☐ Yes ☐ No
   a. If yes, name and dosage: _____
7. Do you have any abnormalities on an EKG or X-ray: ☐ Yes ☐ No
   a. If yes, please give details: _____

TIA/CVA seizures ☐ Yes ☐ No

1. Date of episode: _____ How many episodes? _____ Residuals? _____
2. Type of treatment or medication: _____

Crohn's disease/colitis ☐ Yes ☐ No

1. Date of diagnosis: _____ Any surgery? ☐ Yes ☐ No
   a. If yes, what? _____
2. Date of last episode: _____ Current medications: _____
3. Hospitalization: ☐ Yes ☐ No
   a. If yes, when and why? _____

Psychiatric ☐ Yes ☐ No

1. Diagnosis: _____ Date of diagnosis: _____
2. Hospitalization: ☐ Yes ☐ No
   a. If yes, when and why? _____
3. Suicide attempts? ☐ Yes ☐ No
4. Currently employed? ☐ Yes ☐ No

Substance abuse ☐ Yes ☐ No

1. Date stopped using: _____ Duration used: _____
2. Substance used: _____ Amount used: _____
3. Type of treatment: _____
4. Attend AA or other program? ☐ Yes ☐ No
5. Any relapses? ☐ Yes ☐ No
6. Are liver functions normal? ☐ Yes ☐ No
   a. If no, give readings: _____
7. Any motor vehicle violations or DUIs? ☐ Yes ☐ No
   a. If yes, give details: _____

_____

_____

Avocation risks

1. Are you a pilot? ☐ Yes ☐ No
   a. If yes, answer the following:

   How many total hours flown? _____

   Are you IFR-rated? ☐ Yes ☐ No

   How many flights do you fly per year? _____

   Do you participate in underwater diving, bungee jumping, mountain climbing, hang gliding, parasailing, parachuting, skydiving, ballooning, or motor vehicle racing? ☐ Yes ☐ No

   If yes, please explain: _____

_____

_____

Any impairment not listed? ☐ Yes ☐ No

1. If yes, diagnosis and date: _____
2. Treatment: _____
3. Medications and dosages: _____
4. Date of last follow-up: _____ Test results: _____

Additional comments:

_____

_____

_____

_____