Sheikh Medical Care

PLLC103-02 93RD ST, OZONE PARK,
New York 11417
Tel: 718-487-3944
Fax: 718-487-3929
E-mail : sheikhmedicalcarepllc@gmail.com

ANNUAL PREVENTIVE HEALTH HISTORY

Name: _____ **Date:** _____

DO YOU HAVE ANY HEALTH CONCERNS? _____

1. NUTRITION

Describe your normal routine of eating on the day time:					
Breakfast:					
Brunch:					
Lunch:					
Afternoon Snack:					
Dinner:					
Do you crave Salt?	○ Yes	○ No	Do you crave Carbohydrates?	○ Yes	○ No
Do you crave Sugar?	○ Yes	○ No			
Are you taking protein in bulk?	○ Yes	○ No	Do you skip other meals every day?	○ Yes	○ No
Do you often skip Breakfast?	○ Yes	○ No		○ Yes	○ No
Do you eat around 3 hrs or less prior to going to sleep?	○ Yes	○ No			
How many times do you eat processed/packaged foods a week?					
Do you eat white pasta, white rice, or white breads?	○ Yes	○ No			
Do you drink fresh fruit juices?	○ Yes	○ No	Do you eat Fast Food?	○ Yes	○ No
Do you take energy drinks?	○ Yes	○ No	How much?		
Are you addicted to drink coffee?	○ Yes	○ No	Tea?	○ Yes	○ No
What do you prefer to add to your tea or coffee?					
Do you make use of artificial sweeteners? Which ones?					
How much water do you drink per day?					
How many fruit serving do you eat every day?					
How many vegetable servings do you eat every day?					

2. EXERCISE

Do you exercise on a daily basis?	○ Yes ○ No	If you answered "No" please note why?
Are you performing cardiovascular exercises?	○ Yes ○ No	Circle the types: ○ Walking ○ Treadmill ○ Elliptical ○ Bicycle ○ Running ○ Yoga ○ Other:
Do you perform any kind of strength training exercises?	○ Yes ○ No	Circle the types: ○ Weights ○ Yoga ○ Other:
Do you perform balance, stretching, or flexibility training exercises?	○ Yes ○ No	Circle the types: ○ Yoga ○ Other:
How many minutes or hours do you exercise every session?	10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ >60 ○ Other: ○	

How many days per week do you actually exercise?	0 1 2 3 4 5 6 7

3. SLEEP

How many hours do you exactly sleep for?	○ <5 ○ 6 ○ 7 ○ 8 ○ 9 ○ >10	
How long does it typically take you to fall asleep?	○ <15 mm ○ 30 mm ○ 45 mm ○ 60 mm ○ >60 mm	
Do you take anything to assist you in sleeping properly?	○ Yes ○ No	Describe what you take?
Do you usually wake up in the middle of the night?	○ Yes ○ No	Describe why?
Do you go right back to sleep instantly after you wake up mostly?	○ Yes ○ No	Describe why?
Do you snore a lot?	○ Yes ○ No	
Do you normally wake up tired?	○ Yes ○ No	
Do you take short naps during the day time?	○ Yes ○ No	What specific time of the day & for how long?

4. EMOTIONAL HEALTH

Do you often feel depressed?	○ Yes ○ No	Describe why?
Do you feel anxious most of the time?	○ Yes ○ No	Describe why?
Do you have any big stressors in your life?	○ Yes ○ No	Describe why?

5. HEALTH AND FITNESS GOALS

What are your two major fitness and health goals?

a.

Why is it essential for you?

What really keeps you from attaining this?

b.

Why is this necessary to you?

What keeps you from attaining this?

Are you presently following any kind of nutrition plan?

Do you gain weight very easily?

Do you tend to do on & off diets?

Do you have a tough time losing your weight?

How long has it been since you were at your desired weight?

6. HEALTH SCREENING

Test	Date last performed	Test	Date last performed
Bone Density		Bone Density	
Breast Exam		Breast Exam	
Calcium Heart Score		Calcium Heart Score	
Colonoscopy		Colonoscopy	
Dental Exam		Dental Exam	

7. RISK FACTORS

Do you drink caffeine?	◯ Yes ◯ No	How many drinks every week?
Do you drink alcohol?	◯ Yes ◯ No	
Do you use tobacco products?	◯ Yes ◯ No	Describe why?
Do you use illicit drugs?	◯ Yes ◯ No	How many packs every day?

8. REVIEW OF SYSTEMS

Mark if you currently have or have had within the last few months any of the following Droblems or concerns

GENERAL	CV (heart)	GU (urinary)	PSYCHIATRY
☐ Abnormal bleeding	☐ Chest discomfort	☐ Blood in urine	☐ Anxiety
☐ Abnormal bruising	☐ Chest pain	☐ Inability to control bladder	☐ Depression
☐ Chills	☐ Difficulty breathing @ night	☐ Inability to empty bladder	☐ Hallucinations
☐ Cold intolerance	☐ Exercise intolerance	☐ Frequent urination	☐ Suicidal thoughts
☐ Dizziness	☐ Leg cramps with exercise	☐ Genital sores	☐ Violent thoughts
☐ Fainting	☐ Palpitations	☐ Lack of sexual drive	**MEN ONLY**
☐ Fatigue	☐ Racing heart beats	☐ Night time urination	☐ Erection problems
☐ Fever	☐ Swelling	☐ Painful urination	☐ Lump in testicle
☐ Flushing	**RESP (lungs)**	☐ Urinary urgency	☐ Penis discharge
☐ Heat intolerance	☐ Breathing problems	☐ Weak urinary stream	☐ Sore on penis
☐ Loss of appetite	☐ Cough	**Muscles and Joints**	**WOMEN ONLY**
☐ Lymph node enlarge	☐ Coughing up blood	☐ Back pain	☐ Abnormal PAP
☐ Night sweats	☐ Joint pain	☐ Joint pain	☐ Breast lump
☐ Sleep disturbance	☐ Snoring	☐ Joint swelling	☐ Breast pain
☐ Thirst excessive	☐ Sputum	☐ Morning stiffness	☐ Heavy bleeding
☐ Weight gain	☐ Wheezing	☐ Muscle cramps	☐ Hot flashes
☐ Weight loss	**GI (gastrointestinal)**	☐ Muscle weakness	☐ Irregular periods
Eyes	☐ Abdominal pain	**SKIN**	☐ Nipple discharge
☐ Blurry vision	☐ Black tarry stools	☐ Change in moles	☐ Painful intercourse
☐ Double vision	☐ Bloating	☐ Excessive dry skin	☐ Painful periods
☐ Dry Eyes	☐ Bloody stools	☐ Hair loss	☐ Vaginal discharge
☐ Eye discharge	☐ Change in bowel habits	☐ Hives	☐ Vaginal itching
☐ Eye pain	☐ Constipation	☐ Itching	
☐ Floaters	☐ Diarrhea	☐ Nail changes	
☐ Light sensitivity	☐ Excessive gas	☐ Rash	
☐ Vision loss	☐ Heartburn & indigestion	☐ Skin cancer	
Ears, Nose,Throat	☐ Hemorrhoids	☐ Sores non-healing	
☐ Bleeding gums	☐ Nausea	**NEUROLOGY**	
☐ Earache	☐ Swallowing difficulty	☐ Concentration difficulty	
☐ Ear discharge	☐ Swallowing pain	☐ Falling down	
☐ Hearing loss	☐ Vomiting	☐ Headaches	
☐ Hoarseness	☐ Vomiting blood	☐ Numbness or tingling	
☐ Nasal congestion		☐ Paralysis	
☐ Nosebleeds		☐ Poor balance	
☐ Ringing in the ears		☐ Seizures	
☐ Seasonal allergies		☐ Tremors	
☐ Sore throat		☐ Weakness	
☐ Vertigo			

Patient Name: _____

Physician Reviewed: _____ Date: _____