Patient Name _____ Age _____ Appointment Date _____
(First & Last Name)

COMPREHENSIVE HEALTH ASSESSMENT

1. **GOALS:** Why have you decided to consult with Dr. Daya?
   What would you most like to achieve through your care at our office?

- _____
- _____
- _____

2. **MAJOR SYMPTOMS**: Please list in order of importance, from most concerning to least, along with the duration of your symptoms.

Symptoms	Duration
• _____	• _____
• _____	• _____
• _____	• _____
• _____	• _____
• _____	• _____

3. **PAST MEDICAL HISTORY:** Please note that **it is helpful if you can ask the hospital(s) to forward copies of your medical records. We have medical release forms if needed.**

a) **Medical Problems:** List any other serious medical problems you have had during your lifetime (including childhood):

Diagnosis / Illness	Treatment	Year
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

Continued – PAST MEDICAL HISTORY: Please note that it is helpful if you can ask the hospital(s) to forward copies of your medical records. We have medical release forms if needed.

b) Preventative Health Maintenance: Please indicate approx. when you **last** had the following & results if known:

Exam	**Year**	**Results if known**
Annual Exam	• _____	• _____
Colonoscopy	• _____	• _____
Upper Endoscopy	• _____	• _____
EKG	• _____	• _____
Exercise Stress Test	• _____	• _____
Nuclear Stress Test	• _____	• _____
Stress Echocardiogram	• _____	• _____
Echocardiogram	• _____	• _____
Carotid Doppler	• _____	• _____
Aortic Aneurysm Evaluation	• _____	• _____
Bone Density	• _____	• _____
Sleep Study	• _____	• _____
Chest X-ray / CT Chest	• _____	• _____
Dental Visit	• _____	• _____
Eye Exam	• _____	• _____
Skin Cancer Screen	• _____	• _____
Hearing Evaluation	• _____	• _____
For Females: Mammogram	• _____	• _____
For Females: Pap Smear	• _____	• _____
For Males: Prostate Exam	• _____	• _____
For Males: Testicular Exam	• _____	• _____

c) Vaccines: Please indicate approx. when you **last** had the following:

- Influenza Vaccine Year _____
- Pneumonia Vaccine _____
- Tetanus Vaccine Year _____
- Shingles Vaccine Year _____
- Covid-19 Vaccine Month & Year _____
- Other Type / Year _____

d) Overnight Hospitalization: List any other overnight hospitalizations:

Reason for hospitalization	Hospital	Year
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

e) Operations / Surgeries: List any operations or surgeries you have had:

Type of operation	Hospital	Year
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

f) Medications: List all of the prescriptions and over-the-counter medications you are currently taking. *It is helpful if you bring your pills with you*.

Name of medication	Strength (mg)	# per day	Why prescribed?
• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____

Continued – PAST MEDICAL HISTORY: Please note that it is helpful if you can ask the hospital(s) to forward copies of your medical records. We have medical release forms if needed.

g) Allergic Reactions: List any medications to which you may have had an allergic or adverse reaction:

Medication	**Type of reaction**	**Year**
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

h) Vitamins / Supplements: List any vitamins or supplements that you are taking. *Please bring these with you to the exam*.

Name of supplement	**# taken daily**	**Why are you taking this?**
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

i) Health Practitioner Visits: Please list other doctors, chiropractors, psychologists, acupuncturists or other health practitioners that you have seen in the past 2 years:

Name of practitioner	**Type of practice**	**When seen** (mm/yyyy)
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

4. FAMILY HISTORY: It is important to look at the health of your relatives to assess possible genetic influences on your own health. Describe the following:

a) Mother's health: _____

_____

b) Father's health: _____

_____

c) Brother(s) health: _____

_____

d) Sister(s) health: _____

_____

e) Your children(s) health *(include ages)*: _____

_____

f) Your maternal grandparent's health: _____

_____

g) Your paternal grandparent's health: _____

_____

5. SOCIAL HISTORY

a) Occupation: _____

b) Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

c) Hobbies: _____

d) Exercise frequency per week: _____

6. PREVENTION: Are you interested in any of the following aspects of prevention? (Please check any or all in which you may be interested.

a) ☐ Exercise	e) ☐ Weight gain	i) ☐ Heart disease prevention
b) ☐ Nutrition	f) ☐ Finding motivation	j) ☐ Accident prevention
c) ☐ Decreasing stress	g) ☐ Changing bad habits	
d) ☐ Weight loss	h) ☐ Cancer prevention	

• Are there any other health problems you are concerned about preventing? ☐ Yes ☐ No

If yes, please describe: _____

7. RISK FACTORS: Please check (✓) **yes** or **no** for each.

a) Do you currently smoke cigarettes? ☐ Yes ☐ No
If yes, how many per day? _____

b) Did you smoke cigarettes in the past? ☐ Yes ☐ No
If yes, how many per day? _____ *& for how many years* _____

c) Do you currently smoke e-cigarettes, cigars or a pipe? ☐ Yes ☐ No

d) Do you drink alcohol? ☐ Yes ☐ No
If yes, how many glasses per week? _____

e) Have you ever felt you should cut down on drinking alcohol? ☐ Yes ☐ No

f) Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

g) Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No

h) Have you ever had an alcoholic drink first thing in the morning to steady your nerves or to get rid of a handover? ☐ Yes ☐ No

i) Treatment for alcohol or drug-related problems ☐ Yes ☐ No

j) Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes, how many per day _____

k) Do you wear a seatbelt when you drive? ☐ Yes ☐ No

l) Do you wear sunscreen when you are outside? ☐ Yes ☐ No

m) Do you have operational smoke detectors in your home? ☐ Yes ☐ No

n) Do you have operational Carbon-dioxide detectors in your home? ☐ Yes ☐ No

o) Do you have a Living Will / Power of Attorney for healthcare? ☐ Yes ☐ No

p) Have you ever received or been exposed to blood products or transfusions? ☐ Yes ☐ No

q) Have you had or have metallic teeth fillings? ☐ Yes ☐ No

r) Do you have any artificial joints or implants? ☐ Yes ☐ No

s) Did you receive multiple antibiotic treatments as a child? ☐ Yes ☐ No

8. SYSTEMS REVIEW: In this section, please consider each body system. If you have had, within the last 6 months, any of the listed symptoms, please check (✓).

OVERALL	Low energy		**NECK**	Thyroid problem	
	Poor appetite			Lump in neck	
	Unintentional weight loss			Neck injury	
	Unintentional weight gain			Arthritis	
	Sleep disturbance			Pain in neck	
	Fever			Frequent sore throats	
	Other:			Decreased movement	
HEAD	Injury			Other:	
	Headaches		**CHEST**	Shortness of breath (rest/exertional)	
	Migranes			Cough	
	Other:			Asthma	
EYES	Double vision			Chest pain	
	Glaucoma			Coughing up blood or sputum	
	Glasses / contact lenses			Wheezing	
	Itchy eyes			Bronchitis	
	Recent vision change			Pneumonia	
	Difficulty seeing			Emphysema	
	Pain in eyes			Sleep apnea	
	Other:			Other:	
NOSE	Frequent congestion		**BREASTS**	Do you feel a lump	
	Sinus problems			Discharge from the nipple	
	Bloody nose			Previous biopsy pain	
	Polyps			Change in breast size	
	Allergies			Concern regarding size	
	Deviated septum			Pain	
	Hay fever			Other:	
	Snoring		**HEART**	Palpitations	
	Other:			Angina	
MOUTH	Sores in mouth			Heart attack	
	Bleeding gums			Chest pain	
	Gum infection			Chest pain with exertion	
	Bad breath			Irregular heart beat	
	Bad taste			Heart murmur	
	Dental problems			Rheumatic fever	
	Tongue soreness			History of heart problems	
	Cold sores			Other:	
	Dry mouth				
	Other:				

ABDOMEN	Abdominal pain		**REPRODUCTIVE (female)**	Sore on genitals	
	Nausea			Vaginal discharge	
	Indigestion			Painful periods	
	Vomiting			Irregular periods	
	Diarrhea			Vaginal dryness, pain or odor	
	Heartburn			Premenstrual symptoms	
	Constipation			Pain with intercourse	
	Blood in stool			Sexual difficulty	
	Colitis			Abnormal pap smear	
	Bloating			Infection in tubes or pelvis	
	Excess gas			Endometriosis	
	Hemorrhoids			Menopausal symptoms	
	Rectal pain			Other:	
	Liver trouble		**REPRODUCTIVE (male)**	Sore on genitals	
	History of ulcer			Discharge from penis	
	Gallbladder problem			Erectile dysfunction	
	Other:			Difficulty with sexual relations	
BONES/BACK	Back pain			Pain with ejaculation	
	Disc problem			Other:	
	Back injury		**REPRODUCTIVE (both)**	Gonorrhea	
	Osteoporosis			Herpes	
	Limited movement			Syphilis	
	Bone pain			Chlamydia	
	Pain with walking/sitting			Genital warts	
	Muscle aches			History of venereal disease	
	Athletic injury			Other:	
	Other:		**SKIN**	Unhealing sore	
URINARY	Painful urination			Mole that concerns you	
	Blood in urine			Easy bruising	
	Dribbling after urination			Rash	
	Urinating at night			Itching	
	Decreased stream			Dry skin	
	Frequent urination			Skin cancer	
	Incontinence (loss of urine)			Psoriasis	
	Pain in kidneys			Athlete's foot	
	Kidney stone			Nail fungus	
	Frequent infections			Other:	
	Protein in urine				
	Prostate problem				

NEUROLOGICAL	Dizziness		**HEMATOLOGIC/ LYMPHATIC**	Easy bruising	
	Dizzy spell			Excessive bleeding	
	Convulsion			Lymphadenopathy	
	Tingling			Blood transfusions	
	Memory loss			Other:	
	Fuzzy thinking		**ENDOCRINE**	Hair loss	
	Loss of balance			Hirsuitism	
	Tremor/shaking			Temperature intolerances	
	Blackout spell			Hot flashes	
	Numbness			Night sweats	
	Poor coordination			Thyroid disorder	
	Weakness in arms, legs, body			Osteoporosis	
	Difficulty with speech			Other:	
	History of neurological problem				
	Other:				

PSYCHOLOGICAL	Lack of Pleasure		Bad temper		**Current Stressors:**	√
	Anxiety		Fatigue		Family	
	Change in appetite		Panic attacks		Relationships	
	Change in sleep habits		Phobias		Work	
	Crying spells		Attempted suicide		Financial	
	Difficulty concentrating		Thoughts of suicide		Other	
	Feelings of guilt		History of psychotherapy			
	Feelings of sadness					
	Feelings of worthlessness					
	Indecisiveness					
	Weight change					

9. NUTRITION: Please check (✓) next to the food/drink that applies to your current diet.

	Usual Breakfast	✓		**Usual Lunch**	✓		**Usual Dinner**	✓
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

a) Are you on a special diet? *eg: diabetic, dairy restricted, vegetarian, vegan etc* ☐ Yes ☐ No

b) Is there anything special about your diet that we should know? ☐ Yes ☐ No
If yes, please explain below:

_____

c) List any foods you are allergic or sensitive to:

_____

_____

10. SLEEP HYGIENE QUESTIONNAIRE: Please check (✓) all that apply.

☐ BMI >30 ☐ Heart Disease ☐ Frequent Nighttime Urination ☐ Depression
☐ Memory Loss ☐ Stroke ☐ Narcolepsy ☐ Diabetes (Type II) ☐ Obesity
☐ Insomnia ☐ Restless Legs

			Points
Have you been told that you stop breathing while asleep?	☐ Yes	☐ No	**8**
Have you ever fallen asleep or nodded off while driving?	☐ Yes	☐ No	**6**
Do you awaken suddenly with shortness of breath, gasping or with your heart racing?	☐ Yes	☐ No	**6**
Do you feel excessively sleepy during the day?	☐ Yes	☐ No	**4**
Has anyone ever told you that you snore while sleeping?	☐ Yes	☐ No	**4**
Have you had weight gain and found it difficult to lose?	☐ Yes	☐ No	**2**
Have you taken medication for or been diagnosed with high blood pressure?	☐ Yes	☐ No	**2**
Do you kick or jerk your legs while sleeping?	☐ Yes	☐ No	**3**
Do you feel burning, tingling, or crawling sensations in your legs while you wake up?	☐ Yes	☐ No	**3**
Do you wake up with headaches during the night or in the morning?	☐ Yes	☐ No	**3**
Do you have trouble falling asleep?	☐ Yes	☐ No	**4**
Do you have trouble staying asleep once you fall asleep?	☐ Yes	☐ No	**4**

Total all points together that you have answered "Yes" to ——————> Score & Risk Factor _____

LOW	MODERATE	HIGH	SEVERE
0-7	8-11	12-15	16+

11. TESTOSTERONE QUESTIONNAIRE (<u>MALES ONLY</u>): Please check (✓) **yes** or **no** for each.

1.	Has your sex drive decreased?	☐ Yes	☐ No
2.	Are your erections less strong?	☐ Yes	☐ No
3.	Do you have a decrease in strength and/or endurance?	☐ Yes	☐ No
4.	Have you lost height?	☐ Yes	☐ No
5.	Are you sad and/or grumpy?	☐ Yes	☐ No
6.	Do you have a lack of energy?	☐ Yes	☐ No
7.	Have you noticed a recent deterioration in your ability to play sports?	☐ Yes	☐ No
8.	Are you falling asleep after dinner?	☐ Yes	☐ No
9.	Has there been a recent deterioration in your work performance?	☐ Yes	☐ No
10.	Have you noticed a decrease "enjoyment in life"?	☐ Yes	☐ No

ALLERGY HEALTH ASSESSMENT

Patient Name _____ D.O.B. _____

Were you referred by another doctor: ☐ Yes ☐ No If yes, Doctor's Name: _____

1) SYMPTOMS: Please check (✓) all recurrent symptoms:

Nasal Symptoms	✓	**Sinus Symptoms**	✓	**Chest/Throat Symptoms**	✓	**Skin Symptoms**	✓
Runny nose		Post nasal drainage		Wheezing		Itching	
Nasal congestion		Frequent throat clearing		Chest tightness		Eczema	
Sneezing		Sinus pressure		Shortness of breath		Hives	
Itchy eyes		Headache		Cough		Swelling	
Watery eyes		Colored nasal mucous		Wheezing with exercise		Blisters	
Itchy nose		Stuffy ears		Difficulty breathing at night		Contact Allegry	
Itchy ears		Frequent sinus infections		Frequent pneumonia		Other:	
Itchy throat		Bad breath		Throat tightness			
Decreased taste or smell		Snoring		Hoarse voice			
Other:		Other:		Other:			

a) How long have you had these Symptoms?

Nasal _____ ☐ Days ☐ Weeks ☐ Months ☐ Years
Sinus _____ ☐ Days ☐ Weeks ☐ Months ☐ Years
Chest _____ ☐ Days ☐ Weeks ☐ Months ☐ Years
Skin _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

b) How often do the symptoms occur?

Nasal ☐ constant ☐ daily ☐ weekly ☐ monthly ☐ off-and-on
Sinus ☐ constant ☐ daily ☐ weekly ☐ monthly ☐ off-and-on
Chest/Throat ☐ constant ☐ daily ☐ weekly ☐ monthly ☐ off-and-on
Skin ☐ constant ☐ daily ☐ weekly ☐ monthly ☐ off-and-on

c) Is there any seasonal variation in your symptoms? ☐ Yes ☐ No
If so, when are they worse? *(Spring, Summer, Autumn or Winter)*

Nasal _____ **Sinus** _____ **Chest** _____ **Skin** _____

d) What medications have you tried for your allergy symptoms?

_____

_____

2) YOUR ENVIRONMENT: Please check (✓) what environmental triggers have made your symptoms worse:

☐ Mowed grass ☐ Windy weather ☐ Dust ☐ Spending time outdoors ☐ Moldy places
☐ Sweeping or dusting ☐ Cigarette smoke ☐ Pollen ☐ Insect sting ☐ Exercise
☐ Weather changes ☐ Respiratory infections ☐ Cold air ☐ Night time
☐ Laughing ☐ Stressful events ☐ Animals (specify) _____
Perfumes, cosmetics, odors, etc. (specify) _____

a) How long have you lived in this area? _____

b) Where else have you lived? _____

c) Are you better or worse in this area? ☐ Better ☐ Worse

d) Do you have any pets? ☐ Yes ☐ No If yes, please list: _____

e) Are symptoms worse when around your pet? ☐ Yes ☐ No

f) Any previous pets in the home? ☐ Yes ☐ No

g) Any smokers in the home? ☐ Yes ☐ No

h) Type of Home: ☐ Apartment/Condo ☐ House

i) Has your home had water or flood damage? ☐ Yes ☐ No

j) What kind of work do you do? _____

k) Are symptoms worse at work? ☐ Yes ☐ No

l) Have you travelled out of the country in the past year? ☐ Yes ☐ No
If yes, where? _____

m) Are there other households you visit frequently? ☐ Yes ☐ No
If yes, please explain: _____

n) Family members with allergies/asthma? ☐ Mother ☐ Father ☐ Siblings

o) Any medications that you do not tolerate? ☐ Yes ☐ No
If yes, list the medications and the reaction they caused: _____

_____

_____

p) Any foods that you do not tolerate? ☐ Yes ☐ No
If yes, list the foods and the reaction they caused: _____

_____

_____

3) MEDICAL HISTORY: Please check (✓) all that apply:

Cataracts	☐	Frequent nose bleeds	☐
High Blood Pressure	☐	Enlarged heart	☐
Acid Reflux	☐	Diabetes	☐
Stroke	☐	Kidney disease	☐
Glaucoma	☐	Nasal polyps	☐
Coronary artery disease	☐	Lung disease	☐
Migraine headaches	☐	Thyroid disorder	☐
Hearing loss	☐	Cancer	☐
Irregular heartbeat	☐	Eartubes	☐
Inflammatory bowel disease	☐	Snoring	☐
Seizure disorder	☐	Sleep Apnea	☐
Pituitary disorder	☐	Arthritis	☐
Osteoporosis	☐	Other:	☐

4) PREVIOUS ALLEGY TREATEMNT: Please check (✓) and / fill out, all that apply:

a) Other doctors seen for allergies: ☐ ENT ☐ Allergist ☐ Pulmonologist ☐ Dermatologist ☐ Gastroenterologist

b) Have you had nasal or sinus surgery? ☐ Yes ☐ No

If yes, when and what were the results? _____

c) Have you been treated in urgent care or ER with asthma? ☐ Yes ☐ No

If yes, Last visit date? _____

d) Have you had allergy tests? ☐ Yes ☐ No

If yes, when and where? _____

e) Have you had allergy shots? ☐ Yes ☐ No

If yes, when and where? _____

5) SOCIAL HISTORY: Please check (✓) and / or fill out, all that apply:

a) Do you now or have you ever smoked? ☐ Yes ☐ No

If yes, how much _____ & for how long _____

b) Is there anything else you would like to share regarding your allergies? ☐ Yes ☐ No

c) If you could fix one thing about your allergies, what would it be? _____

_____

DAYAMED, INC.

Thank you for completing this Questionnaire.

STEP 1:

Save the completed Health Questionnaire Form for your records by clicking the button below.

SAVE THIS FORM

STEP 2:

Email this completed packet to the office by clicking the button below.

EMAIL THIS FORM