Elite Health Evaluation
Health & Lifestyle Assessment

Renue Health wants to assure you that all of the information provided below will remain strictly confidential. When providing your contact information, please be aware that these numbers will be used for medically related and financial correspondence only. Thank you.

DATE: ________________

Contact Information

Name: ____

Date of Birth: _____________ Age: ___________

Address: ____

____

Home Phone: ____________________________________

Cell: ____________________________________

Personal Fax: ____________________________________

Personal Email: ____________________________________

Business Phone: ____________________________________

Business Fax: ____________________________________

Business Email: ____________________________________

Where do you prefer to be contacted? Mark all options that apply.

- ❒ Home
- ❒ Cell
- ❒ Business

How do you wish to receive correspondence? Mark all options that apply.

- ❒ Phone
- ❒ Email
- ❒ Fax

Primary Care Physician: ____

Office Phone: ____

Address: ____

____

Personal

Sex: ❒Male ❒Female

Height: ____________

Body Frame (Choose one):

- ❒ Small
- ❒ Medium
- ❒ Large

Weight:

Current: _____lbs Lowest: _____lbs Highest: ____ lbs Ideal: ____lbs

How would you rate your current health?

- ❒ Excellent
- ❒ Good
- ❒ Average
- ❒ Fair
- ❒ Poor

What are your Age Management Medical goals?

____
____
____
____
____
____
____
____

Personal Health History

When was the last time you went to the doctor for a general check up or an illness?

___

If any significant illnesses or hospitalizations in the recent past, please specify:

___

Please list any surgical procedures you have had, including plastic surgery, along with the approximate date.

___

Please list any history of trauma that you have experienced (i.e. car accidents, head injuries, broken bones).

___

Please indicate if you are currently receiving or have ever received any of the following:

- ❐ Radiation Therapy — Condition: ______________________________
- ❐ Chemotherapy — Condition: ______________________________

Are you allergic to any foods? ______ If yes, please list the food(s) and describe the reaction.

___

Are you allergic to any drugs? ______ If yes, please list the drug(s) and describe the reaction.

___

Please list all medication including dosage and frequency (prescription and/or over-the-counter) you currently take and the condition for which it is taken.

Medication	Condition	Dosage	Times per day

Please list all supplements including dosage and frequency (i.e. vitamins, herbs, nutritional supplements) you currently take and the condition for which it is taken. You may feel free to copy the labels and forward them along with your completed questionnaire.

Supplement	Condition	Dosage	Times per day

Please review the list of conditions and **check mark** the column(s) that most applies to you and your family history. Leave blank any condition(s) you wish to discuss privately with your Institute Physician.

Condition	Myself	Mother	Father	Maternal Grandparents	Paternal Grandparents	Sibling
Heart Disease	❒	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒	❒
High Cholesterol	❒	❒	❒	❒	❒	❒
Lung Disease	❒	❒	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	❒	❒
Gastrointestinal Disorders	❒	❒	❒	❒	❒	❒
Kidney/Bladder Disease	❒	❒	❒	❒	❒	❒
Thyroid Disorders	❒	❒	❒	❒	❒	❒
Neurological Disorders	❒	❒	❒	❒	❒	❒
Mental Health Issues	❒	❒	❒	❒	❒	❒
Osteoporosis	❒	❒	❒	❒	❒	❒
	❒	❒	❒	❒	❒	❒
	❒	❒	❒	❒	❒	❒
	❒	❒	❒	❒	❒	❒

Please provide an explanation for any items for which you checked **myself.**

Review of Overall Health

Under the categories listed below, check the “yes” column **only** if you are experiencing the listed symptom to a **substantial** or **unusual** degree.

General:

Symptom	Yes	No
Frequent Infections or Illness	❒	❒
Fatigue	❒	❒
Lumps in Neck, Armpits, Groin or Breast	❒	❒
Breast or Nipple Tenderness/Swelling	❒	❒
Insomnia	❒	❒
Hypersomnia (Sleep too Much)	❒	❒
Sleep Apnea/Snoring	❒	❒
Excessive Daytime Sleepiness despite Adequate Sleep	❒	❒
Night Sweats	❒	❒
Hot Flashes	❒	❒
Unintentional Weight Loss/Difficulty Gaining Weight	❒	❒
Unintentional Weight Gain/Difficulty Losing Weight	❒	❒

Skin and Hair:

Symptom	Yes	No
Dry/Brittle and/or Flaky Hair	❒	❒
Hair Thinning or Falling Out or Hair Grows Very Slowly	❒	❒
Dry Skin	❒	❒
Acne	❒	❒
Persistent Rash	❒	❒
Hives	❒	❒
Persistent Generalized Itching	❒	❒
Excessive Sweating	❒	❒

Eyes/Ears/Nose/Throat:

Symptom	Yes	No
Visual Disturbances (e.g. blurred, tunneled, etc.)	❒	❒
Hearing Loss	❒	❒
Ringing in the Ears	❒	❒
Nosebleeds	❒	❒
Stuffy Nose	❒	❒
Sinus Infections	❒	❒
Sore Throat/Hoarseness	❒	❒

Under the categories listed below, check the “yes” column **only** if you are experiencing the listed symptom to a **substantial** or **unusual** degree.

Cardiopulmonary:

Symptom	Yes	No
Chest Pain at Rest	❒	❒
Chest Pain with Exertion	❒	❒
Chest Pain Radiating Into Left Arm or Shoulder	❒	❒
Palpitations/Rapid or Irregular Heartbeat	❒	❒
High Blood Pressure	❒	❒
Low Blood Pressure	❒	❒
Leg/Calf Pain While Walking	❒	❒
Fluid Retention (e.g. Swollen Ankles, Legs, etc.)	❒	❒
Shortness of Breath	❒	❒
Wheezing	❒	❒
Difficulty Breathing while Lying Flat	❒	❒

Metabolic/Endocrine:

Symptom	Yes	No
Swollen (Bulging) Eyes	❒	❒
Hypersensitivity to Cold/Cold Hands and Feet	❒	❒
Body Temperature below 97.6 Degrees Fahrenheit	❒	❒
Thinning or Loss of Outside Portion of Eyebrow	❒	❒
Unintentional Weight Loss of More Than 10 lbs. in Last 6 Months	❒	❒
Unintentional Weight Gain of More Than 10 lbs. in Last 6 Months	❒	❒
Hot Flashes/Excessive Sweating	❒	❒
Excessive Thirst	❒	❒
Excessive Hunger	❒	❒
Excessive Urination	❒	❒
Crave Salty Foods	❒	❒
Crave Sweet Foods	❒	❒
Experience Fatigue, Irritability, or Cravings after Eating Sweets	❒	❒
Irritable, Tired, or Weak When Meal is Missed	❒	❒
Need to Drink Caffeine to Get Going	❒	❒

Gastrointestinal:

Symptom	Yes	No
Abdominal Pain	❒	❒
Nausea and/or Vomiting	❒	❒
Heartburn/Reflux	❒	❒
Difficulty Swallowing or Pain with Swallowing	❒	❒
Flatulence (Gas) or Bloating	❒	❒
Diarrhea	❒	❒
Constipation (Hard or Effortful Bowel Movements)	❒	❒
Blood in Stool	❒	❒
Hemorrhoids	❒	❒

Under the categories listed below, check the "yes" column **only** if you are experiencing the listed symptom to a **substantial** or **unusual** degree.

Neurological:

Symptom	**Yes**	**No**
Headaches	❒	❒
Faintness/Light Headedness	❒	❒
Dizziness/Vertigo	❒	❒
Balance Problems	❒	❒
Tingling or Numbness	❒	❒
Muscle Weakness	❒	❒
Tremors	❒	❒
Memory Problems/Attention or Concentration Problems	❒	❒
Loss of Smell or Taste	❒	❒
History of Seizure/Convulsions	❒	❒
Carpal Tunnel Syndrome	❒	❒

Musculoskeletal:

Symptom	**Yes**	**No**
Joint Pain, Swelling, or Stiffness	❒	❒
Arthritis (if yes, Specify Type)______________________________	❒	❒
Back Pain/Neck Pain	❒	❒
Limited Motion	❒	❒
Muscle Tension or Spasms	❒	❒
Fibromyalgia	❒	❒

Mind and Emotions:

Symptom	**Yes**	**No**
Moodiness/Irritability	❒	❒
Depression	❒	❒
Anxiety/Excessive Worrying	❒	❒
Excessive Stress	❒	❒
Restlessness, Hyperactivity, or Inability to Relax	❒	❒

Kidney/Bladder:

Symptom	**Yes**	**No**
Difficulty Initiating/Maintaining Urinary Stream/Dribbling	❒	❒
Frequent Urination	❒	❒
Pain with Urination	❒	❒
Frequent Urinary Tract Infection	❒	❒
Loss of Bladder Control/Leaking Urine	❒	❒
Incomplete Bladder Emptying	❒	❒
Excessive Nighttime Urination (specify number of times) ________	❒	❒
Blood in Urine	❒	❒
Kidney Stones	❒	❒

Women … continue to page 10

Males Only:

Do you use Viagra, Cialis, Levitra or any other erectile enhancement drugs? ❒Yes ❒No

If yes, which one(s) and how often?

____

____

Have these drugs helped you? ❒ Yes ❒ No

Have you ever used any other medications for sexual function? ❒ Yes ❒ No

If yes, please list and describe results:

____

____

Have you ever used testosterone, HCG, DHEA, or HGH? ❒ Yes ❒ No

If yes, which one(s) and when?

____

____

Under the categories listed below, check the “yes” column **only** if you are experiencing the listed symptom to a **substantial** or **unusual** degree.

Symptom	**Yes**	**No**
Difficulty Attaining/Maintaining Erection	❒	❒
Sex Drive: Underactive	❒	❒
Sex Drive: Overactive	❒	❒
History of Infertility/Low Sperm Count	❒	❒
Lack of Early Morning Erections	❒	❒
Lump or Mass in Scrotum	❒	❒
Past or Present Sexually Transmitted Disease	❒	❒

If so, specify:

____

____

Male Screening and Diagnostic Procedures:

Please advise if tests listed below have been completed. If yes, provide the most recent date and results.

Exam:	**Yes**	**No**	**Test Date & Results:**
Prostate Exam	❒	❒	________________
PSA	❒	❒	________________
Colonoscopy/Sigmoidoscopy	❒	❒	________________
Rectal Exam	❒	❒	________________
EKG	❒	❒	________________
Stress Test	❒	❒	________________
Nuclear Stress Test	❒	❒	________________
Chest X-ray	❒	❒	________________
Eye Exam/Eye Pressures	❒	❒	________________

Men … continue to page 12

Females Only:

Are you still menstruating? ❒ Yes ❒ No

If yes, date of last menstrual period: ______________

Every how many days does cycle/bleeding occur: __________________

Would you describe cycle as ❒ Irregular ❒ Regular

Would you describe flow as ❒ Light ❒ Moderate ❒ Heavy

Form of birth control: ❒ None ❒ Hormonal contraceptive ❒ IUD
❒ Diaphragm ❒ Condom ❒ Tubal Ligation ❒ Hysterectomy
❒ Vasectomy (partner) ❒ other_________

Have you had a hysterectomy? ❒ Yes ❒ No

If yes, please provide date and reason:

____

____

Have you ever taken estrogen, progesterone, testosterone, DHEA, or HGH? ❒ Yes ❒ No

If yes, which one(s) and when?

____

____

Under the categories listed below, check the "yes" column **only** if you are experiencing the listed symptom to a **substantial** or **unusual** degree.

Symptom	Yes	No
Menstrual Pain	❒	❒
Hot Flashes/Night Sweats	❒	❒
Sex Drive: Underactive	❒	❒
Pre-Menstrual Syndrome (PMS)	❒	❒
Vaginal Dryness	❒	❒
Vaginal Itching	❒	❒
Pain with Intercourse	❒	❒
Urinary Incontinence/Leaking	❒	❒
Fluid Retention/Bloating	❒	❒
Breast Tenderness	❒	❒
History of Infertility	❒	❒
History of Miscarriages	❒	❒
History of Ovarian Cysts	❒	❒
History of Uterine Cysts/Fibroids	❒	❒
History of Endometriosis	❒	❒
Past or Present Sexually Transmitted Disease	❒	❒

If so, specify:

____

____

Female Screening and Diagnostic Procedures:

Please advise if tests listed below have been completed. If yes, provide the most recent date and results.

Exam:	Yes	No	Test Date & Results:
Pap Smear/Pelvic exam	❒	❒	____________________
Pelvic Ultrasound	❒	❒	____________________
Breast Exam	❒	❒	____________________
Mammogram	❒	❒	____________________
Colonoscopy/Sigmoidoscopy	❒	❒	____________________
Rectal Exam	❒	❒	____________________
EKG	❒	❒	____________________
Stress Test	❒	❒	____________________
Nuclear Stress Test	❒	❒	____________________
Chest X-ray	❒	❒	____________________
Eye Exam/Eye Pressures	❒	❒	____________________

Lifestyle Summary

Marital Status: ❒ Single ❒ Married ❒ Significant Other ❒ Divorced ❒ Widowed

Do you have any children? ❒ Yes ❒ No If yes, how many? __________

Occupation: ____

How many servings of an alcoholic beverage do you consume in an average week?
Note: A serving is defined as a 12-ounce beer, 5-ounce glass of wine, or 1.5 ounces of liquor.

____

____

For Present and Past Tobacco Users:

Do you currently use tobacco? ❒ Yes ❒ No

If yes, what type? (Check all that apply)

❒ Cigarettes How many per day? _____
❒ Pipe How much per day? _____
❒ Snuff How much per day? _____
❒ Cigars How many per day? _____
❒ Chewing tobacco How much per day? _____

If you previously used tobacco, what type did you use? (Check all that apply)

❒ Cigarettes How many per day? _____
❒ Pipe How much per day? _____
❒ Snuff How much per day? _____
❒ Cigars How many per day? _____
❒ Chewing tobacco How much per day? _____

How many years did you use tobacco? ______________________________

When did you quit? ____

How many times have you tried to quit? ______________________________

Do you use a seat belt?

❒ Always ❒ Most of the Time ❒ Sometimes ❒ Never

Do you have a working smoke detector? ❒ Yes ❒ No

Do you have a working carbon monoxide detector? ❒ Yes ❒ No

Personal Assessment & Stress Management

Are you experiencing stress?
❒ Yes ❒ No

How well do you feel you are able to manage stress?
❒ Excellent ❒ Good ❒ Average ❒ Fair ❒ Poor

From the list, select all the methods you use to relieve tension and/or stress:

❒ Read ❒ Meditate ❒ Do Nothing
❒ Listen to Music/Play Music ❒ Blow Up ❒ Turn to Faith/Pray
❒ Smoke Cigarettes/Pipe ❒ Eat ❒ Take a Drug
❒ Sleep ❒ Exercise or walk ❒ Go for a drive
❒ Watch Television ❒ Don't Think About It ❒ Call a Friend/Relative
❒ Cry ❒ Work/Housework ❒ Draw/Paint/Hobby
❒ Throw Things ❒ Alcoholic Beverage ❒ Time with Friend/Relative
❒ Other, please list:
____

Do you experience any of the following symptoms when under stress? (Select all that apply):
❒ Inability to Sleep ❒ Chest Pain ❒ Nervousness
❒ Upset Stomach ❒ Irritability ❒ None of These Symptoms
❒ Other, please explain:
____
____

On average, how many hours of restful sleep do you get per night? ____________

How many hours of sleep do you think you need? ____________

During the past month, what percent of the time would you say you wake up feeling fresh and fully rested?
____

What are your hobbies? ____________

Do you travel outside the country? ❒ Yes ❒ No
If yes, please list the countries you have visited in the last 5 years:
____
____

Fitness and Exercise Summary

Please fill out the chart below to reflect a typical weekly exercise program. List all applicable modes of exercise.

Cardiovascular Exercise

MODE (i.e. Treadmill, Biking, Swimming etc.)	DURATION Minutes/Hours	FREQUENCY Times per week	INTENSITY Low, medium, high, intervals

Explain your level of experience: Novice, Intermediate, Advanced

Resistance Training

MODE (i.e. Free Weights, Machines, Core Conditioning, etc.)	DURATION Minutes/Hours	FREQUENCY Times per week	INTENSITY Low, medium, high, intervals

Explain your level of experience: Novice, Intermediate, Advanced

Flexibility

MODE (i.e. Passive Stretching, Yoga, Pilates, etc.)	DURATION Minutes/Hours	FREQUENCY Times per week	INTENSITY Low, medium, high, intervals

Explain your level of experience: Novice, Intermediate, Advanced

Fitness Activity Assessment

Do you enjoy exercising?	❒ Yes	❒ No
Have you ever been a member of a health club?	❒ Yes	❒ No
If yes, for how long? _____________		
Are you currently a member of a health club?	❒ Yes	❒ No
Have you ever worked with a personal trainer?	❒ Yes	❒ No
If yes, for how long? _____________		
Did you enjoy it?	❒ Yes	❒ No
Are you still with a personal trainer?	❒ Yes	❒ No
Do you have an exercise partner?	❒ Yes	❒ No
If yes, do they improve your workouts?	❒ Yes	❒ No
Are you presently receiving physical therapy?	❒ Yes	❒ No

If yes, please describe:

____

____

Do you have any exercise equipment at home? ❒ Yes ❒ No
(bike, treadmill, free weights, etc.)

If yes, please list:

____

____

If exercise is not part of your weekly routine, please explain the reasons.

____

____

____

During the last year, have you experienced any injuries? ❒ Yes ❒ No

If yes, please describe your injury?

____

____

____

Did this injury occur as a result of exercising? ❒ Yes ❒ No

Did injury cause you to modify/stop exercise program? ❒ Yes ❒ No

If yes, for what period of time did you stop exercising? ______________________

Nutritional Summary

Are you currently following a specific diet? ❐ Yes ❐ No
If yes, please specify:

____

____

When do you notice hunger the most?
❐ Morning ❐ Lunch time ❐ Mid-afternoon ❐ Dinner ❐ Evening ❐ Never

Do you cook or have healthy meals/snacks prepared on a regular basis?
❐ Yes ❐ No

Do you select certain foods because they require less effort?
❐ Yes ❐ No

Where are you most likely to make poor food choices?
❐ Home ❐ Work ❐ Travel

Do you skip meals?
❐ Yes ❐ No

If so, which meal/meals to you skip?
❐ Morning ❐ Lunch time ❐ Mid-afternoon ❐ Dinner

How many meals per week to you eat at restaurants or fast food chains?

Breakfast:	❐ 0 - 2	❐ 3 - 5	❐ More than 6
Lunch:	❐ 0 - 2	❐ 3 - 5	❐ More than 6
Dinner:	❐ 0 - 2	❐ 3 - 5	❐ More than 6

Please list the top three restaurants you frequently visit:
1.______________________ 2.____________________ 3.___________________

Do you consume what most would consider an unusually large amount of food?
❐ Never ❐ Sometimes ❐ Always

What specific foods do you overeat?
❐ Packaged Snacks ❐ Bread ❐ Pastas ❐ Potatoes
❐ Rice ❐ Desserts ❐ Sugary foods ❐ Meats
❐ Other, please list all: ____

Do you crave or have an increased sensitivity to sweets or foods high in carbohydrates resulting in increased irritability, tiredness, or depression?
❐ Yes ❐ No

Note situations, moods, or occasions that cause you to eat or drink more than you should.

____

____

Current Nutritional Intake

In order to accurately assess your current nutrient intake, we need to understand your current eating habits. Please fill out the following nutritional summary in detail for what you consider your average healthy eating day and most unhealthy eating day. This will give us an idea of your strengths and weaknesses and enable us to make suggestions for positive change. List the foods and portions you eat, not those you plan to eat.

- Be specific with portion sizes. If you don't know how many ounces or cups something is, give us a reference. For example: 1 large apple (baseball sized), broiled chicken (about the size of two decks of cards).
- Include any extras you may consume, such as cream or sugar in your coffee, after dinner mints, nibbles of baked goods, candy, etc.
- Don't forget to list beverages (*Diet Coke*, coffee, water, green tea, etc.).

Healthiest Day

Meal/Snack (Time)	Food	Portion size or estimation	Leave blank for our comments
Breakfast Time: ____			
AM Snack Time: ____			
Lunch Time: ____			
Midday Snack Time: _____			
Dinner Time: ____			
PM Snack Time: _____			
Before Bed Snack Time: _____			

Most Unhealthy Day

Meal/Snack (Time)	Food	Portion size or estimation	Leave blank for our comments
Breakfast Time: ____			
AM Snack Time: ____			
Lunch Time: ____			
Midday Snack Time: _____			
Dinner Time: ____			
PM Snack Time: _____			
Before Bed Snack Time: _____			

How many days per week do you have a healthy eating day? ___________________________

How many days per week to you have an unhealthy eating day? ________________________

Please note any specific problem foods you consistently overeat, including the frequency (i.e. daily, weekly, or monthly).

____

____

____

Please list any specific food sensitivities and describe reaction.

____

____

Please fill in answers below to assist your counselor in creating recommendations.

Beverages	Frequency
Water	ounces_____/day
Tea	servings_____/day
Coffee	servings_____/day
Juice	servings_____/day
Diet Soda	servings_____/day
Regular Soda	servings_____/day
Sports Drink	servings_____/day
Flavored Water	servings_____/day
Energy Drink	servings_____/day

Preferred Protein Sources	YES	NO
Fish	❒	❒
Eggs	❒	❒
Chicken	❒	❒
Turkey	❒	❒
Shellfish	❒	❒
Pork	❒	❒
Red Meat	❒	❒
Cottage Cheese	❒	❒
Yogurt	❒	❒
Soy Products	❒	❒

Preferred Fat Sources	YES	NO
Grocery Store Peanut Butter (ex. Skippy, JIF)	❒	❒
Natural Nut Butters (ex. cashew, almond, peanut)	❒	❒
Smoked/Salted Nuts	❒	❒
Dry Roasted/Raw/Unsalted Nuts	❒	❒
Vegetable Oil	❒	❒
Canola Oil	❒	❒
Olive Oil	❒	❒
Assorted Cheeses	❒	❒
Butter	❒	❒
Margarine	❒	❒
Avocado	❒	❒
Hummus	❒	❒

Please fill in answers below to assist your counselor in creating recommendations.

Preferred Carbohydrate Sources	**YES**	**NO**
Cereals	❒	❒
Quick Oatmeal (ex. Quaker)	❒	❒
Oatmeal (steel cut, slow cooked)	❒	❒
White/Wheat Bread	❒	❒
Sprouted Grain/Spelt Bread	❒	❒
Potatoes	❒	❒
Sweet Potatoes	❒	❒
White/Jasmine Rice	❒	❒
Brown/Basmati Rice	❒	❒
Quinoa	❒	❒
Other Whole Grains	❒	❒
Pastas/Noodles	❒	❒
Fruits	❒	❒
Vegetables	❒	❒
Chips/Pretzels/Popcorn/Candy	❒	❒

Your Future Lifestyle

What changes would you like to accomplish in the next year?

____
____
____
____

How would accomplishing your goals in the program impact your life?

____
____
____
____

For you to be successful in accomplishing your goals, what will be the biggest challenge for you to overcome?

____
____
____
____

Do you have a lifelong goal that you have put on the “back burner” because of your current state of wellbeing?

____
____
____
____

On a scale from 1 to 10 how inspired are you right now to dedicate yourself to achieving the goals that you have mentioned here?

____
____
____
____