Patient Health History

Concentra totalcare

Screening ID#:

Date: Patient Name:

Reason for visit: Speci c Health Concern:

Lifestyle Practices: (Please circle your response or complete eld as indicated)

Do you eat breakfast most days of the week?	No	Yes			
How many cups of milk or milk products (cheese, yogurt, etc) do you eat per day?	None	1 2	3 4	>4	
How many fruits and vegetables do you eat on a daily basis?	None	1 2	3 4	5 6	>6
How many sodas do you drink per day on average?	None	1 2	3 4	5 6	>6
Do you take supplements such as Calcium, vitamin D, or folic acid?	No	Yes - please list:			
How many days per week do you exercise?	None	1 2	3 4	5 6	>6
When exercising, how many minutes do you exercise?	<15	15 30	31 45	46 60	>60
How many hours per week do you work or study?	<15	15 30	31 45	46 60	>60
How many hours of sleep on average do you get per night?	<5	5 6	7 8	9 10	>10
Who lives at home with you?	No one	Spouse/partner	Roommate		
	Parents	Children ages:			
Do you use tobacco products?	No	Yes, ☐ packs/day	☐ cigars/day	☐ # cans/week	
How often did you have a drink containing alcohol (such as beer, wine, cocktail, shot, or wine cooler) in the past year?	Never	<1X/month	2-4X/month	2-3X/week	>4X/week
How many drinks did you have on a typical day when you were drinking in the past year?	1-2	3-4	5-6	7-9	10 or more
How often did you have 6 or more drinks on one occasion in the past year?	Never	< Monthly	Monthly	Weekly	Daily
Do you use illicit drugs or medication for non-medical (recreational) use?	No	Yes - if so, what?			
Do you use seat belts when driving or riding in a car?	No	Yes			
Do you wear hearing protection when exposed to loud noise?	No	Yes			
How often do you operate a vehicle after using alcohol-containing drinks?	Never	Sometimes	Regularly		
How often do you use a have or sun screen when spending time outdoors?	Never	Sometimes	Regularly		