AMERICAN COLLEGE OF Lifestyle Medicine

LOMA LINDA UNIVERSITY HEALTH

Produced in collaboration with Loma Linda University

# Preventive Services Assessment

## GETTING STARTED

a. Indicate your CURRENT LEVEL OF HEALTH - Rate on scale of 0 as very poor and10 as excellent

**Select your level by clicking on the drop-down arrow on the blue shaded box** 0

b. Please rank the top **3 areas** you would like to improve with 1 being the most important and 3 the least important.

| | | | | | |
|---|---|---|---|---|---|
| Sleep | _____ | Weight Management | _____ | Nutrition | _____ |
| Exercise | _____ | Purpose & Connection | _____ | Mental Health | _____ |
| Substance Use | _____ | | | | |

**Select your response by clicking on the drop-down arrow on the blue shaded box**

**Rate on scale of 0 as unimportant and10 as extremely important**

c. How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address? 0

d. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address? 0

e. How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address? 0

f. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address? 0

g. How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address? 0

h. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address? 0

i. **What would you like to gain from this lifestyle visit?** *Check all that apply*

| | | |
|---|---|---|
| ☐ More medical/scientific knowledge | ☐ Practical health tips | ☐ Other: _____ |
| ☐ Accountability | ☐ Personalized plan | |

Patient Name:_____ DOB: _____

## PREVENTIVE SERVICES

a. Have you had a physical exam and/or "Wellness" Visit in the past 12 months? ● No ○ Yes ○ I don't know
If yes, list date and outcome: _____

b. Have you had a dental exam and teeth cleaning in the past 12 months? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

c. Have you been screened for diabetes with blood work? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

d. Have you had your cholesterol, lipids or triglycerides measured? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

e. Have you ever had a bone density test to check for osteoporosis? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

f. Do you have any balance problems or have had a fall in the last 6 months? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

g. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

h. Do you have any concerns about your ability to drive safely or have you had any car accidents in the past 12 months? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

i. Do you have any concerns about your memory? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

j. Do you have any trouble with your hearing? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

k. Have you had your eyes checked for vision problems? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

l. Have you ever had your metabolism or thyroid checked? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

m. Have you ever been told that you have a sexually transmitted disease/infection? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

n. If you smoke, have you ever had an abdominal ultrasound to check for possible aneurysms? ○ No ○ Yes ○ I don't know
If yes, list date and outcome: _____

o. Have you ever received counseling behavioral therapy for any of the following problems?

☐ Weight management or obesity ☐ Nutrition ☐ Smoking or use of other nicotine products ☐ Alcohol use

p. Which of the following screenings have you completed

☐ Colon cancer screen (stool test or colonoscopy ☐ Breast cancer screen (mammogram) ☐ Cervical cancer screen (PAP smear)

☐ HIV/AIDS blood work screen ☐ Hepatitis C blood work screen ☐ Depression or sadness screen

q. Have you had the following vaccines?

☐ Flu ☐ Hepatitis B ☐ Pneumococcal or Pneumonia

Patient Name:_____ DOB: _____