



**Ask an Expert
&
Metabolic Syndrome Program
Application & Health History
FY09**

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|-------------------|
| For Internal Use: |
| Expert: _____ |
| Appointment_____ |
| _____ |
| Expert:_____ |
| Appointment_____ |
| _____ |
| Case: |
| Data: |
| Email: |

| | |
|--|----------------|
| What program would you like to join? | |
| <input type="checkbox"/> Ask An Expert – Dietitian <input type="checkbox"/> Ask A (you may check both diet and exercise) | |
| <input type="checkbox"/> Metabolic Syndrome Program | |
| Name: | Gender: M F |
| Birth date: | Age: |
| E-mail: | Work phone: |
| Home phone: | Cell phone: |
| What is the best way to contact you during normal business hours? | |
| Mailing address (street, city, state, ZIP): | |
| How did you find out about this program? (Please Check one) | |
| <input type="checkbox"/> MUS Wellness Choices Newsletter <input type="checkbox"/> My campus flyer <input type="checkbox"/> WellAwards <input type="checkbox"/> Referred by a professional <input type="checkbox"/> Referred by a friend or former participant | |

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|----------------------------|--|
| Campus affiliation: | Do you have other health insurance? |
| MSU Billings | MSU Bozeman |
| UM Montana Tech | UM Western |
| Dawson Community College | MSU, Great Falls COT |
| MSU Northern | Helena COT |
| Helen – OCHE | Flathead Valley Community College |
| Miles Community College | UM, Missoula |
| UM, Missoula COT | |
| | Yes No |

| | | |
|------------------------|-------------------------------------|-------------------------|
| Insurance plan: | Allegiance Traditional | Allegiance Managed Care |
| | Blue Cross Blue Shield Managed Care | New West Managed Care |
| | New West Medicare (Pilot) | Peak Managed Care |

(This information is optional for Ask An Expert but REQUIRED for Metabolic Syndrome Program.)

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| Have you been diagnosed with diabetes? Yes No | |
| Check the boxes next to any of the following statements that apply to you. Use your most recent measurements. | |
| My triglycerides (TG): | <input type="checkbox"/> I am taking medication for high TG levels. |
| My blood pressure is : | <input type="checkbox"/> I am taking medication for high blood pressure. |
| My HDL is : | <input type="checkbox"/> I am taking medication for low HDL levels. |
| My fasting blood glucose is: | <input type="checkbox"/> I am taking medication for high blood sugars. |
| My waist measurement is: | |

General Health Questions - Required

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| Do you smoke or chew tobacco? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you drink alcoholic beverages? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you ever have pain in your chest or heart? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you ever notice extra heartbeats or skipped beats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you ever bothered by nausea and/or dizziness for no apparent reason? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your physician ever said that you have a heart condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

How tall are you? How much do you weigh? pounds

How much did you weigh 3 months ago? pounds

If you are currently being treated for any medical conditions, please list them here:

List all current medications:

| Medication | Purpose | Dosage |
|------------|---------|--------|
| | | |
| | | |
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| | | |
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| | | |

List all current dietary supplements (vitamins, minerals, herbs, etc.) and over-the-counter medications:

| Supplement or Medication | Purpose or Desired Effect | Dosage |
|--------------------------|---------------------------|--------|
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| | | |
| | | |

Brief Exercise Questionnaire – Required for exercise assistance

| Do you have any injuries or exercise limitations? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|-------------------------------|------------------------------|-----------------------------|
| If so, please describe: | | | |
| Are you physically active? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, please describe your typical weekly activities below: | | | |
| Activity | Length of Each Session | Weekly Frequency | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| How many hours do you work each week? | | | |
| How would you describe your typical physical activity level at work? | | | |
| What activities, sports, and hobbies do you really enjoy? | | | |
| “Fitness” means different things to different people. What does “being fit” mean to you? | | | |

Your Personal Health & Wellness Goals - Required

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| What are your goals for participating in this program? |
| 1. |
| 2. |
| 3. |
| 4. |

Brief Nutrition Questionnaire – Required for diet assistance

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|---|------------------------------|-----------------------------|
| Do you have any food allergies or intolerances? If yes, please explain: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any other dietary restrictions or strong food preferences? If yes, please explain: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | | |
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| Describe all of the meals, snacks, and beverages that you consumed yesterday: | | |
| | Time | <u>What</u> and <u>how much</u> did you eat and drink? |
| When did you wake up? | | |
| When was the first time that you ate or drank yesterday? | | |
| Did you eat or drink anything between breakfast and lunch? | | |
| When did you eat lunch? | | |
| Did you eat or drink anything between lunch and dinner? | | |
| When did you eat dinner? | | |
| Did you eat or drink anything after dinner? | | |
| When did you go to bed? | | |

A medical release is required for the Metabolic Syndrome Program and may be required for the Ask An Expert Program. Please provide the following information and we will contact your health care provider:

Name of doctor/health care provider:

Fax number for doctor/health care provider:

Phone for doctor/health care provider:

Address for doctor/health care provider:

I understand that the MUS Wellness Program will be contacting my health care provider to obtain a medical release for my participation:

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| <p>For your confidentiality, print this form and mail it or fax it to:</p> <p>MUS Wellness, Attention Lisa Hofman Curry Health Center 108 The University of Montana Missoula, MT 59812</p> <p>Fax: 406-243-4695</p> |
|---|

Signature: _____ Date: _____