EXECUTIVE HEALTH CARE
HEALTH QUESTIONNAIRE
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I. GENERAL INFORMATION **Date of Exam _____**

Name: _____
(Full "legal" name including middle initial)
Occupation: _____ Date of Birth: _____ Age: _____

Home Address: _____ Home Tel: _____
_____ Work Tel:_____
Cell Phone:_____
E-mail: _____

PHARMACY NAME:_____

PHARMACY PHONE NUMBER:_____

II. GENERAL HEALTH INFORMATION

1. **Medicines (prescription and nonprescription, including vitamins, herbals, hormones, aspirin, or birth control)(provide separate list if necessary)— Please include strength and frequency:**
   _____
   _____
   _____

2. **Allergies:**
   a. Medicines _____
   Please specific reaction (hives, nausea, etc.)_____
   b. Environmental/Seasonal _____
   (Include Bees, Latex, Tape, iodine, shellfish)

3. **Immunizations – please list all immunizations received outside of Minnesota (we can access your immunization history in the state of Minnesota):**
   _____
   _____
   _____

4. **Overall Health Status Perception:**
   a. Unhealthy/Ill 0 1 2 3 4 5 6 7 8 9 10 Very Healthy

III. MEDICAL/SURGICAL HISTORY

1. **Hospitalizations** (reason/date/place)

2. **Surgeries** (type/date/complications)

3. **General Medical Conditions**
   ____ Coronary Artery Disease (heart attack, angina, congestive heart failure
   ____ Cancer (including skin)
   ____ Colon and/or polyps
   ____ Diabetes
   ____ Elevated or high blood pressure
   ____ High cholesterol
   ____ Abnormal chest x-ray
   ____ Stroke/TIA
   ____ Alcohol/drug abuse/chemical dependency treatment
   ____ Anxiety/depression/mental illness
   ____ Tuberculosis/abnormal skin test (mantoux)
   ____ Sexually transmitted disease
   ____ Tobacco
   Explanation: _____
   _____
   _____

4. **Disease of the following organ systems:**
   a. Coronary artery disease risk factors
   ____ Family History (member younger than 65 with heart disease)
   ____ Obesity
   ____ Sedentary lifestyle
   ____ Excessive Stress
   ____ Smoker
   ____ Diabetes
   ____ High Cholesterol (LDL > 130, Total cholesterol > 200)
   ____ High Blood Pressure (> 120/80)
   ____ Angina (chest pain/pressure)
   ____ Congestive Heart Failure
   ____ Valvular heart disease (aortic or mitral valve problem)
   ____ Previous artery bypass surgery, balloon procedure, or stent
   Explanation: _____
   _____
   _____

b. Oncology/Hematology (Cancer/Blood)—History of the following:
____ Lung or colon cancer
____ Breast or ovary cancer
____ Anemia (low hemoglobin or low red cell count)
____ Bleeding tendency or history of blood transfusion
____ Abnormality of white cells or immune deficiency
____ Enlarged lymph nodes or spleen
____ Other type of cancer (skin, e.g.)
Explanation: _____
_____
_____

c. Pulmonary (Lungs)
____ Emphysema
____ Asthma (allergic or exercise-induced)
____ Chronic bronchitis
____ Tuberculosis
____ Other lung disease
Explanation: _____
_____
_____

d. Eyes/Ears/Nose/Throat
____ Cataracts
____ Glaucoma
____ Macular Degeneration
____ Frequent sinus infections
____ Other
Explanation: _____
_____
_____

e. Gastroenterology (Digestive Tract)
____ Ulcers
____ Gallstones
____ Hepatitis
____ Jaundice
____ Cirrhosis
____ Pancreatitis
____ Inflammatory bowel disease (Crohn's or Ulcerative Colitis)
____ Heartburn/Acid Reflux
Explanation: _____
_____
_____

f. Renal/Genitourinary (Kidney/Bladder/Genital)
____ Urinary tract infection
____ Kidney failure
____ Bladder dysfunction/incontinence
____ Prostatitis
____ Erectile dysfunction
Women: Last menstrual period _____
Last pelvic exam/PAP _____
Last breast exam _____
Possibly pregnant? _____
Menstrual concerns? _____
Explanation: _____
_____
_____

g. Rheumatology (Joints and soft tissue)
____ Arthritis
____ Injuries/Fractures
____ Tendonitis/bursitis/fasciitis
____ Spine (neck or back) problems
____ Chronic pain
Explanation: _____
_____
_____

h. Metabolic/Endocrine
____ Thyroid or parathyroid
____ Pituitary or adrenal glands
____ Testicle or ovary problems
____ Osteoporosis or osteopenia
Explanation: _____
_____
_____

i. Neuropsychological
____ Depression/Anxiety disorder
____ Phobias
____ Sleep disorder (insomnia, sleepwalking, talking, snoring/apnea)
____ Obsessive/Compulsive disorder
Explanation: _____
_____
_____

j. Infectious Disease
____ STD (sexually transmitted disease, including HPV or warts)
____ Risk group for HIV/AIDS
Explanation: _____
_____
_____

k. Dermatology
____ Rash/Dermatitis/Sores (includes eczema, psoriasis, fungal)
____ Skin Cancer
Explanation: _____
_____
_____

IV. LIFESTYLE

1. Smoking/Tobacco

____ I use tobacco in the form of ____ cigarettes ____ chew/snuff
Frequency _____
For how many years? _____
____ I wish to quit
____ I quit tobacco ____ years ago after ____ years of use
____ I have **never** used tobacco

2. Alcohol

____ I drink alcohol at least once a week
Ounces per week (one ounce = approx. one beer, one glass of wine, or one shot of alcohol) ____
____ I have felt that I should cut down on drinking
____ I have been annoyed by others criticizing my drinking
____ I have had a morning "eye opener"
____ I have felt badly or guilty about my drinking
____ I **do not** use alcohol on a regular basis

3. Other

____ I have used/do use recreational drugs (list): _____
_____

4. Nutrition/Metabolism

Current Height _____ Current Weight _____
Ideal weight _____
____ My weight has changed recently
The following factors make it difficult for me to eat right
____ Eating out ____ Taking large portions ____ Frequent snacking
____ Dislike recommended foods ____ Someone else cooks
____ I am on a special diet (describe) _____
____ I eat at least two fruits and vegetables daily
____ I would like a formal dietary consultation

5. Activity/Exercise

I am ____VERY ____ MODERATELY ____ HARDLY physically active
My activities include (type, frequency, time spent, duration in months):
_____
_____
____ I have physical problems that limit my activity
____ I would like to have a fitness assessment
____ I have downloads from my Apple Watch I can submit

6. **Sleep/Rest**

Average hours of sleep per night: ____
____ I usually wake up refreshed
____ I feel sleep deprived
____ I have difficulty sleeping or getting to sleep, or rely on sleep aides
____ I have concerns with snoring and/or sleep apnea
Explanation: _____
_____

7. **Cognitive/Perceptual**

____ I have difficulty with my hearing
____ I have difficulty with my vision
____ I have difficulty learning or have a diagnosed learning disability
____ I have concerns regarding perceived memory, attention deficit, recall, etc.
Explanation: _____
_____

8. **Roles/Relationships**

____ Married ___Single ___Divorced ___Separated ___Committed relationship
____ Number of children
____ Number of children living at home
____ Number of persons in household
Occupation _____
Education Level Completed/Degree _____
How many roles do you have (check all that apply)
___ Friend ___ Child ___ Parent ___ Employer ___ Employee
___ Spouse ___ Caretaker ___ Community Volunteer ___ Other

9. **Stress/Coping**

____ I feel an excessive amount of stress in my life
Rate the intensity of stress in the following situations (10 is most stress)
a. Work ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10
b. Family ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10
c. Social ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10
d. Finances ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10
e. Health ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10
f. Other ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10
_____

V. PREVENTION MEDICINE

I am interested in or have questions about the following:

____ Screening Ultrasound:
_____ Abdominal Aneurysm (men age 60+, smoking history, family history)
_____ Carotid Arteries (smoking history, elevated cholesterol, family history of stroke or carotid surgeries)
____ Colon cancer screening (Age 50 or older, or family history)
I have had or think I need
____ Colonoscopy (date:_____)

____ STD counseling, or testing for HIV, syphilis, or Chlamydia
____ Pneumonia vaccine (65 and older or history of pneumonia/lung disease)
____ Immunizations for travel (Third world or malaria-endemic areas)
____ Tetanus booster (every 10 years)
____ Shingles vaccine (age >50)
____ Mammography or PAP test (up to annually after 40)
____ Flu shot (seasonal, October through March)
____ Self breast or testicle examinations
____ I routinely do self examinations
____ Counseling on marital or sexual problems
____ Genetic Counseling
____ Cancer risk in family
____ Other disease in the family
____ Other: _____

VI. FAMILY HISTORY—

	Age	If deceased, note cause/age	Medical or other illness
Mother	___	_____	_____
Father	___	_____	_____
Brother(s)	___	_____	_____
	___	_____	_____
	___	_____	_____
Sister(s)	___	_____	_____
	___	_____	_____
	___	_____	_____

Other(s): _____
_____

Other Specific Family History	Family Member (paternal/maternal)/Age of diagnosis
___ Cancer (specify type/location)	_____
___ Stroke	_____
___ Diabetes	_____
___ Thyroid imbalance	_____
___ High blood pressure	_____
___ Birth defects	_____
___ High cholesterol	_____
___ Obesity	_____
___ Liver disease	_____
___ Lung disease	_____
___ Kidney disease	_____
___ Mental Illness	_____
___ Alcoholism	_____
___ Suicide	_____
___ Other Hereditary Conditions	_____

VII. REVIEW OF SYMPTOMS

1. General **Explain:**

___ Fever, chills, sweats

___ Unusual fatigue
___ Unplanned/abrupt weight change

2. **Heart**
   ___ Palpitations (irregular beats)
   ___ Racing beat
   ___ Lightheaded or fainting
   ___ Swelling/water retention
   ___ Breathing trouble at night
   ___ Chest pain/pressure/tightness
3. **Blood**
   ___ Enlarged lymph nodes
   ___ Easy bleeding/bruising
   ___ Previous blood transfusion
4. **Lungs**
   ___ Short of breath
   ___ Mucus/sputum/coughing
   ___ Coughing blood
   ___ Morning throat clearing
   ___ Painful/uncomfortable breathing
   ___ Previous exposure to TB
5. **Head, Eyes, Nose, Throat**
   ___ Headaches/migraines
   ___ Vision change/blurry/double
   ___ Sores in mouth/bleeding gums
   ___ Change in voice/hoarseness
   ___ Sneezing/watery eyes/itchy eyes
   ___ Nosebleeds
   ___ Sinus infection
   ___ Ringing in the ears or hearing loss
   ___ Dizziness or vertigo, balance problems/falls
6. **Digestive**
   ___ Poor appetite
   ___ Indigestion/dyspepsia/heartburn
   ___ Excessive gas
   ___ Diarrhea/constipation
   ___ Bloody or black stools
   ___ Hemorrhoids
   ___ Abdominal pain
   ___ Nausea/vomiting
   ___ Hepatitis/Yellow jaundice
   ___ Painful swallowing or choking
7. **Genitals/Bladder**
   ___ Burning/pain with urination
   ___ Poor stream of urine
   ___ Not emptying bladder well
   ___ History of bladder infections
   ___ Painful intercourse
   ___ Genital rash/sores/bumps
   ___ Urine leakage/accidents

___ Nighttime urination
___ Discharge/odor

8. Muscle/Bone
___ Muscle or joint pain
___ Stiffness or swelling
___ Back or neck pain

9. Endocrine
___ Excessive urination or thirst
___ Change in sexual drive or performance
___ Breast lumps/tenderness/discharge

10. Nervous System
___ Loss of consciousness
___ Numbness/tingling
___ Paralysis/weakness
___ Memory or concentration difficulty

11. Skin
___ Rashes/Sores
___ Changing/growing moles (color/size)
___ Easily sunburned
___ Contact reactions (chemicals, metal, latex, etc)

VIII. STRESS WARNING SIGNALS (CHECK ALL THAT APPLY)

___ Headaches	___ Back pain	___ Indigestion/stomach ache
___ Dizziness/spells	___ Sweaty palms	___ Racing heart/panic
___ Sleep problems	___ Muscle tension	___ Fatigue/tiredness
___ Bossiness	___ Teeth grinding	___ Excessive smoking or drinking
___ Criticizing others	___ Compulsive eating	
___ Compulsive gum Chewing	___ Inability to get things done	
___ Crying	___ Overwhelmed	___ Nervous/jittery
___ Anger/short fuse	___ Lonely	___ Bored
___ Loss of pleasure	___ Powerless	___ Unhappy
___ Forgetfulness	___ Lost creativity	___ Lost sense of humor
___ Worrying	___ Want to run away	___ Difficult to make decisions
___ Can't think clearly		
___ Empty	___ Loss of meaning	___ Unforgiving
___ Self doubt	___ Loss of direction	___ Cynicism
___ Apathy	___ Martyrdom	___ Looking for magic
___ Need to "prove" yourself		
___ Isolation	___ Resentment	___ Intolerance
___ Nagging	___ Hiding	___ Distrust

IX. FOLLOW UP AND REPORTING

<u>Please send my Correspondence by</u>:

E-Mail: _____

By opting to receive my health care correspondence via email, I understand that Executive Health Care takes as many reasonable steps as possible to protect confidentiality during the transmission of electronic information. I acknowledge and take responsibility for the small risk of unintended breaches of privacy, confidentiality, or security relating to email correspondence.

Mail: _____ Home or Other _____

Address:_____

City _____ State _____ Zip _____

____ Flash Drive

By checking this box, I opt to also receive a copy of my executive physical on a flash drive, ***<u>which is not passcode protected</u> to ensure access in a medical emergency****. I acknowledge and take responsibility for any risk of unintended breaches of privacy, confidentiality, or security relating to the flash drive.*

____ Please also send copy of summary to my Primary Care Physician
(If Yes, please complete attached Authorization to release information)

____ I authorize my medical/billing information to be shared with:

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

Signature_____Date_____

Executive Health Care also offers routine medical care to executives for your healthcare needs throughout the year! Check us out at www.ehc.bz for more information or ask Lori (Program Coordinator) for details at (612) 871-6268.

Thank You