

**EXECUTIVE HEALTH CARE
HEALTH QUESTIONNAIRE
www.ehc.bz**

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I. GENERAL INFORMATION

Date of Exam _____

Name: _____
(Full "legal" name including middle initial)

SS# Number: _____

Occupation: _____

Date of Birth: _____ Age: _____

Home Address: _____

Home Tel: _____

Work Tel: _____

Cell Phone: _____

E-mail: _____

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:**

Approx. Date

- a. Tetanus/Diphtheria (DPT) _____
- b. Polio (OPV) _____
- c. MMR (measles/mumps/rubella) _____
- d. Hepatitis A (2 shot series) _____
- e. Hepatitis B (3 shot series) _____
- f. Influenza _____
- g. Pneumovax (pneumonia shot) _____
- h. Other (Yellow Fever, Dengue, etc.) _____
- i. Covid-19 vaccination _____
- i. Do you travel internationally? Yes ___ No ___

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. GENERAL HEALTH HABITS

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

I have seen a dietician for nutritional counseling

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

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

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

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) Colon cancer screening (Age 50 or older, or family history)

I have had or think I need

 Colonoscopy (date:_____) Sigmoidoscopy (date:_____) Barium enema (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)
- Tb skin test (those at high risk of tuberculosis)
- 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
- Routine aspirin use for prevention of heart disease or stroke
- 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
<input type="checkbox"/> Cancer (specify type/location)	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Thyroid imbalance	_____
<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Birth defects	_____
<input type="checkbox"/> High cholesterol	_____
<input type="checkbox"/> Obesity	_____
<input type="checkbox"/> Liver disease	_____
<input type="checkbox"/> Lung disease	_____
<input type="checkbox"/> Kidney disease	_____

VII. REVIEW OF SYMPTOMS

1. General

- Fever, chills, sweats
- Unusual fatigue
- Unplanned/abrupt weight change

Explain:

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)

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

IX. FOLLOW UP AND REPORTING

Please send my Correspondence by:

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, **which is not passcode protected 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