# Monsour executive wellness center



#### executive health client questionairre

**Name:** Click here to enter text.

## Contact Information

 **What name do you prefer to be called?** Click here to enter text.

 **Date of birth:** Click here to enter text. **Gender:** Click here to enter text. **Race:** Click here to enter text.

**Address:** Click here to enter text. **City:** Click here to enter text. **State/Zip:** Click here to enter text.

**Home phone:** Click here to enter text. **Cell:** Click here to enter text.

**E-mail:** Click here to enter text. **Alternate E-mail:** Click here to enter text.

**Employer:** Click here to enter text. **Work phone:** Click here to enter text.

**Will your executive physical be paid for by the employer listed above? Yes** [ ]  **No** [ ]

 **Pharmacy:** Click here to enter text. **Pharmacy phone:** Click here to enter text.

 **Emergency Contact/Relationship:** Click here to enter text. **Phone:** Click here to enter text.

## Please let us know your concerns

 **1.) How do you rate your overall health?**

**Excellent** [ ]  **Good** [ ]  **Fair** [ ]  **Poor** [ ]  **2.) Please state any concerns regarding your health:** Click here to enter text.

**3.) Please state any special testing you are interested in that you would like to discuss with your Executive Health Physician:** Click here to enter text.

**4.) If you were born between 1945 and 1965 have you been tested for the Hepatitis C antibody?**[ ]  **Yes** [ ]  **No** [ ]  **Unsure**The Hepatitis C recommendation is for one time screening of adults born between 1945 and 1965.

**5.) When was your last chest x-ray?** Click here to enter text. **6.) Are you interested in having your chest x-rayed during your executive physical?** [ ]  **Yes** [ ]  **No**

Chestx-rays produce images of your lungs, airways and the bones of your chest. Chest x-rays can also reveal fluid in or around your lungs or air surrounding a lung.
 **7.) As part of your executive physical, a USF Health Family Medicine/Internal Medicine physician will administer a basic dermatologic skin screening. However, you may elect to have a more thorough skin examination performed in the USF Health Dermatology department? Would you like this service added on? Yes** [ ]  **No** [ ]  **8.) Please list any stressors (physical or psychological) in your life that you would like to discuss with your Executive Health Physician:** Click here to enter text.

## Medical History

 **Allergies or drug reactions, please specify the drug and the reaction (i.e. penicillin leads to rash and throat swelling**: Click here to enter text.

Current prescription medications
 **Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text.

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**Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text.

**Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text. **Additional medications:** Click here to enter text.Current over the counter medications/herbal products/vitamins
 **Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text.

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**Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text.

**PHARMACOGENOMICS**

1. Do you take more than two prescription medications on a daily basis? **Yes** [ ]  **No** [ ]
2. Have you ever experienced a bad reaction to a medication causing you to visit the emergency room or be hospitalized? **Yes** [ ]  **No** [ ]
3. Do you sometimes experience unwanted side effects from any of your medications? **Yes** [ ]  **No** [ ]
4. Do you sometimes feel that your medications are not working? **Yes** [ ]  **No** [ ]
5. Are you interested in pharmacogenetic testing to explain your response to current or future medications that you may be prescribed? **Yes** [ ]  **No** [ ]

**Common medications influenced by your genetic makeup**

**Cardiology** **Depression**

Clopidogrel (Plavix®) Citalopram (Celexa®)

Warfarin (Coumadin®) Escitalopram (Lexapro®)

Simvastatin (Zocor®) Paroxetine (Paxil®)

 Fluvoxamine (Luvox®)

 Sertraline (Zoloft®)

 Amitriptyline (Elavil®)

**Epilepsy**  **Gastrointestinal disorders**

Carbamazepine (Tegretol®) Mercaptopurine (Purinethol®)

Phenytoin (Dilantin®) Azathioprine (Imuran®)

**Infectious diseases** **Pain Management**

Abacavir (Ziagen®) Codeine (Tylenol #3®)

Voriconazole (Vfend®) Tramadol (Ultram®)

Pegylated interferon

**Oncology**

Fluorouracil (Fluoroplex®)

Capecitabine (Xeloda®)

Surgical History and Hospitalizations
 **Date of Surgery** Click here to enter text. **Type of Surgery** Click here to enter text.

**Date of Surgery** Click here to enter text. **Type of Surgery** Click here to enter text.

**Date of Surgery** Click here to enter text. **Type of Surgery** Click here to enter text.

Please check if you are bothered by any of these conditions

[ ] **Heart attack**[ ]  **High blood pressure**[ ]  **Chest pain**[ ]  **Palpitations (rapid heartbeat)**[ ]  **High Cholesterol**[ ]  **Diabetes**[ ]  **Stroke**[ ]  **Seizure**[ ]  **Headache**[ ]  **Weight gain**[ ]  **Weight loss**[ ]  **Fever or chills**[ ]  **Night sweats**[ ]  **Eye pain**[ ]  **Vision Problems**[ ]  **Difficulty hearing**[ ]  **Ringing in ears**[ ]  **Chronic runny/stuffy nose**[ ]  **Sinus problems**[ ]  **Spells of unconsciousness**[ ]  **Pain in legs while walking**[ ]  **Swelling of ankles/legs**[ ]  **History of blood clots in legs or lungs**[ ]  **Joint stiffening or swelling**[ ]  **Arthritis**[ ]  **Thyroid disease**[ ]  **Painful urination**[ ]  **Frequent urination
If so, how often?** Click here to enter text.[ ]  **Blood in urine**[ ]  **Kidney stones**[ ]  **Shortness of breath while lying flat**[ ]  **Shortness of breath with exertion**[ ]  **Coughing up mucus**[ ]  **Coughing up blood**[ ]  **Wheezing**[ ]  **Chronic bronchitis**[ ]  **Asthma**[ ]  **Emphysema/COPD**[ ]  **Pneumonia**[ ]  **Anemia (low blood count)**[ ]  **Excessive bleeding or bruising**[ ]  **Hemorrhoids**[ ]  **Loss of appetite**[ ]  **Abdominal pain**[ ]  **Diarrhea**[ ]  **Change in bowel habits**[ ]  **Nausea/vomiting**[ ]  **Constipation**[ ]  **Esophageal reflux/heartburn**[ ]  **Stomach ulcer/gastritis**[ ]  **Yellow jaundice or liver disease**[ ]  **Blood in stool**[ ]  **Black/terry stool**[ ]  **Gallbladder disease**[ ]  **Depression**[ ]  **Anxiety**[ ]  **Previous mental illness**[ ]  **Attempted suicide**[ ]  **Sexually transmitted disease(s)
If yes, what type(s)?** Click here to enter text.

 **Have you ever had a blood transfusion?** [ ]  **Yes** [ ]  **No**

**If yes, when and why?** Click here to enter text.

**Have you ever had or do you presently have cancer?** [ ]  **Yes** [ ]  **No**

**If yes, please list when and what type of cancer.** Click here to enter text.

**Please list any other chronic medical problems/conditions.** Click here to enter text.

Men Only

[ ]  **Discharge from penis** [ ]  **Difficulty with urine stream**[ ]  **Problems with erections** [ ]  **Decrease in sexual drive/desire**

Women only

[ ]  **Vaginal discharge/infections** [ ]  **Painful intercourse**[ ]  **Abnormal vaginal bleeding** [ ]  **Breast lump, pain or nipple discharge**[ ]  **History of abnormal pap smears**

**Date of last menstrual period:** Click here to enter text. **Age of first period:** Click here to enter text. **Age of menopause:** Click here to enter text. **Number of Pregnancies:** Click here to enter text. **Number of children:** Click here to enter text.

 *Bone fracture probability indicators*

**Weight:** Click here to enter text. **Height:** Click here to enter text.

**Are you between the ages of 40 and 90?** [ ]  **Yes** [ ]  **No

Have you had a previous fracture?** [ ]  **Yes** [ ]  **No

Did one of your parents fracture a hip?** [ ]  **Yes** [ ]  **No

Are you a smoker?** [ ]  **Yes** [ ]  **No

Are you taking glucocorticoids?** [ ]  **Yes** [ ]  **No

Do you have rheumatoid arthritis?** [ ]  **Yes** [ ]  **No

Do you have secondary osteoporosis?** [ ]  **Yes** [ ]  **No

Do you drink more than 3 alcoholic beverages per day?** [ ]  **Yes** [ ]  **No

Have you had a (hip) bone mineral density t-scale competed previously?** [ ]  **Yes** [ ]  **No**

## preventative healthcare

Immunizations and Vaccines
 **Indicate the last time the following were performed or “never”

Tetanus:** Click here to enter text. **Pneumovax (pneumonia):** Click here to enter text. **Hepatitis A series:** Click here to enter text. **Hepatitis B series:** Click here to enter text. **Zostavax (shingles):** Click here to enter text. **Other vaccinations:** Click here to enter text.

 **Have you ever been tested for HIV?** [ ]  **Yes** [ ]  **No**

**If yes, what year?** Click here to enter text.

**Would you like to be tested?** [ ]  **Yes** [ ]  **No**

**Would you like STD panel testing? (Gonorrhea, syphilis, chlamydia)** [ ]  **Yes** [ ]  **No**

*The Centers for Disease control and Prevention (cdc) recommends hiv testing for all adults under the age of 65.*

health maintenance tests

**Approximate dates and outcomes

Colonoscopy
Date:** Click here to enter text. **Outcome:** Click here to enter text.
**Would you like help facilitating a colonoscopy within USF Health?** [ ]  **Yes** [ ]  **No
Mammogram (Women only)
Date:** Click here to enter text. **Outcome:** Click here to enter text.

*If more than 10 months, please bring your mammogram films & reports for a comparative study.* **When was your last eye exam?** Click here to enter text. **Was it dilated?** Click here to enter text. **When was your last dental exam?** Click here to enter text. **Have you had an abnormal stress test?** [ ]  **Yes** [ ]  **No

If yes, what kind?** [ ]  **Nuclear** [ ]  **Echo** [ ]  **Treadmill

Can you walk fast on a treadmill for five minutes?** [ ]  **Yes** [ ]  **No**

## social history

**Birthplace:** Click here to enter text. **Where is your primary home?** Click here to enter text. **Occupation:** Click here to enter text. **Are there or have there been any occupational exposures to chemicals, products, noise or other health risks?**[ ]  **Yes** [ ]  **No

If yes, please specify.** Click here to enter text. **Do you use tobacco products?** [ ]  **Yes** [ ]  **No

If yes, which type?** [ ]  **Cigarettes** [ ]  **Cigars** [ ]  **Pipe** [ ]  **Chewing tobacco** [ ]  **Smokeless tobacco

List frequency and length of use.** Click here to enter text. **Do you drink alcoholic beverages?** [ ]  **Yes** [ ]  **No

If yes, list type and frequency.** Click here to enter text.

**Have you ever had a drinking problem?** [ ]  **Yes** [ ]  **No**

**Have you ever tried cutting down or stopping and were unable?** [ ]  **Yes** [ ]  **No**

**Have you ever gotten annoyed by someone for “harassing” you about your drinking?** [ ]  **Yes** [ ]  **No**

**Have you ever felt guilty about your drinking?** [ ]  **Yes** [ ]  **No**

**Do you occasionally have an “eye opener” to get started on the day?** [ ]  **Yes** [ ]  **No

Do you use, or have you used marijuana, cocaine or other street drugs?** [ ]  **Yes** [ ]  **No
If yes, please list type and frequency.** Click here to enter text.

 **How often do you wear your seat belt?** [ ]  **Always** [ ]  **Occasionally** [ ]  **Never

Do you have firearms in your household?** [ ]  **Yes** [ ]  **No
If yes, do you have trigger locks?** [ ]  **Yes** [ ]  **No**

## Nutrition and fitness

 **1.) Do you eat a balanced diet?** [ ]  **Yes** [ ]  **No**

**2.) Please describe any special diet features.** Click here to enter text. **3.) How many cups of coffee, tea, soda or other caffeinated products you drink daily.** Click here to enter text.

**4.) List the total number of waters you drink in a typical day.** Click here to enter text.

Briefly outline your typical diet in an average day

**Breakfast:** Click here to enter text. **Lunch:** Click here to enter text. **Dinner:** Click here to enter text. **Snacks:** Click here to enter text. **Beverages:** Click here to enter text. **5.) Do you consider yourself to be at the appropriate weight?** [ ]  **Yes** [ ]  **No**

**6.) If no, what do you think would be an appropriate weight for you?** Click here to enter text.

**7.) What weight loss diets or plans have you tried in the past year?**[ ]  **Atkins** [ ]  **South Beach** [ ]  **Weight Watchers** [ ]  **Jenny Craig** [ ]  **Other
If other, what kind?** Click here to enter text. **8.) On a scale of 1-10 with 0 being the least motivated and 10 being the most motivated, how would you rate your current motivation to make diet changes?** Click here to enter text.

**9.) How many days per week do you exercise?** Click here to enter text.

Outline your typical weekly exercise routine below
Endurance/Cardiovascular**:
Type:** Click here to enter text. **Duration:** Click here to enter text. **Frequency:** Click here to enter text.

Strength:
**Type:** Click here to enter text. **Duration:** Click here to enter text. **Frequency:** Click here to enter text.

Balance:
**Type:** Click here to enter text. **Duration:** Click here to enter text. **Frequency:** Click here to enter text.

Flexibility:
**Type:** Click here to enter text. **Duration:** Click here to enter text. **Frequency:** Click here to enter text.

## General Well being evaluation

 **Over the past two weeks, how often have you been bothered by any of the following?

1.) Little interest in doing things.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**2.) Feeling down, depressed or hopeless.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**3.) Feeling tired or having little energy.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**4.) Poor appetite or overeating.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**5.) Feeling bad about yourself, feeling that you are a failure or that you have let yourself or your family down.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**6.) Trouble concentrating on things such as reading or watching television.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**7.) Moving or speaking slowly so that others have noticed or the opposite, being fidgety or moving around more than normal.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**8.) Being so restless that it is hard to sit still.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**9.) Thoughts about hurting yourself in some way or that you would be better off dead.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**10.) Feeling nervous, anxious or on edge.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**11.) Not being able to control or stop worrying.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**12.) Worrying too much about different things.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**13.) Have trouble relaxing.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**14.) Becoming easily annoyed or irritated.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**15.) Feeling afraid as if something awful might happen.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

**16.) Trouble falling/staying asleep, sleeping too much.**[ ]  **None** [ ]  **Several days** [ ]  **More than half the days** [ ]  **Nearly every day**

## sleep questionairre

 **1.) On average, How many hours per night do you sleep?** Click here to enter text.

**2.) Do you have trouble falling asleep?** [ ]  **Yes** [ ]  **No**

**3.) Do you have trouble staying asleep?** [ ]  **Yes** [ ]  **No**

**4.) Do you snore?** [ ]  **Yes** [ ]  **No** [ ]  **I don’t know**

**5.) If you snore, how loud is your snoring?**[ ]  **My snoring is as loud as breathing**[ ]  **My snoring is as loud as talking**[ ]  **My snoring is louder than talking**[ ]  **My snoring is very loud**

**6.) How frequently do you snore?** [ ]  **Almost every day** [ ]  **3-4 times per week** [ ]  **1-2 times per week** [ ]  **1-2 times per month** [ ]  **Never or almost never**

**7.) Does your snoring bother other people?** [ ]  **Yes** [ ]  **No**

**8.) Has anyone noticed that you quit breathing during your sleep?**[ ]  **Almost every day**[ ]  **3-4 times per week**[ ]  **1-2 times per week**[ ]  **1-2 times per month**[ ]  **Never or almost never**

**9.) Are you tired after sleeping?**[ ]  **Almost every day**[ ]  **3-4 times per week**[ ]  **1-2 times per week**[ ]  **1-2 times per month**[ ]  **Never or almost never**

**10.) Are you tired during wake time?**[ ]  **Almost every day**[ ]  **3-4 times per week**[ ]  **1-2 times per week**[ ]  **1-2 times per month**[ ]  **Never or almost never**

**11.) Have you ever nodded off or fallen asleep while driving a vehicle?** [ ]  **Yes** [ ]  **No**

**12.) If yes, how often does this occur?** [ ]  **Almost every day** [ ]  **3-4 times per week** [ ]  **1-2 times per week** [ ]  **1-2 times per month** [ ]  **Never or almost never**

## family history

 **1.) Who lives in your home (including pets)?** Click here to enter text.

**2.) Are you married or in a cohabitional relationship?** [ ]  **Yes** [ ]  **No**

**If yes, for how long?** Click here to enter text.

**3.) What is your spouse/partner’s occupation?** Click here to enter text.

**4.) Have you ever been afraid of your spouse/partner?** [ ]  **Yes** [ ]  **No**

**5.) Monogamous (i.e. other partners)?** [ ]  **Yes** [ ]  **No**

**6.) Any sexual concerns?** [ ]  **Yes** [ ]  **No**

 **If yes, please list.** Click here to enter text.

**7.) Are you a caregiver for a family member?** [ ]  **Yes** [ ]  **No**

**If yes, briefly describe your role.** Click here to enter text.

**8.) Do you have a “living will” or other advanced directives?** [ ]  **Yes** [ ]  **No**

**If yes, where is it filed?** Click here to enter text.

**If no, would you like information?** [ ]  **Yes** [ ]  **No**

**9.) Were you adopted?** [ ]  **Yes** [ ]  **No

If no, please complete the following table:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Family member | Gender | Age | Living | Deceased | Illnesses\* | Cause of death | General health |
| Father |  |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Spouse/Partner |  |  |  |  |  |  |  |
| Child  |  |  |  |  |  |  |  |
| Child  |  |  |  |  |  |  |  |
| Child  |  |  |  |  |  |  |  |
| Child  |  |  |  |  |  |  |  |

## Completion

 **Who completed this form?**

[ ]  **Self** [ ]  **Friend** [ ]  **Relative, please list relationship** Click here to enter text.

 **Patient Signature:** Click here to enter text.

**Date:** Click here to enter text.

Thank you for completing the executive client health questionnaire.
It will help us provide you with a customized experience and better care.

# Please return this completed form at least two weeks prior to your executive physical appointment at the monsour executive wellness center

# fax: 813-905-8883 e-mail: executive@health.usf.edu

***I reviewed this patient’s health questionnaire.***

**Executive Wellness Physician Signature:** Click here to enter text.

**Date:** Click here to enter text.