# Monsour executive wellness center



#### executive health client interval questionNaire

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

**Name and Date of Birth:** Click here to enter text.

## Contact Information

**Since your last visit has your address, phone number, email or occupation changed? If so, please list the new information below:**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (home)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**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 & if you have had **any** health changes

**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.

6.) Would you like STD Panel testing? (HIV, Gonorrhea, Syphilis, Chlamydia) Yes  No

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

## new or any changes to previous Medical History

**1.) 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.

2.) Please list ALL medications along with the dose and how often you take it (please include over the counter, vitamins and herbal products):

**3.) Since your last visit have you had any new surgeries? Yes  No**

* If yes, please list with the date:

**4.) Sine your last visit have you had any new medical problems/conditions? Yes  No**

* If yes, please list:

**5.) Have you recently had a blood transfusion? If yes, when and why?**

Review of systems (Ros)- please check if any of these apply to you:

**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.

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.

## preventative healthcare

**Please list any new vaccines with the date that you have received since last visit. (ex: Tetanus, Pneumonia, Shingrix(shingles), Hepatitis A or B series.)**

any **new** health maintenance tests **performed** **outside of last physical:**  
*If more than 10 months and not completed within usf health, please bring your mammogram films & reports for a comparative study.*  
**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. **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 (Please list any changes):

**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.

**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; fitness; and sleeping (please list any changes):

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

**2.) Any nutritional or diet changes since last visit? If so, please specify.   
  
3.) How many cups of coffee, tea, soda or other caffeinated products you drink daily.** Click here to enter text.

**4.) How much water do you typically had in a day.** Click here to enter text. **5.) Any weight changes since last visit?  Yes  No**

**6.) Any concerns with your weight?  Yes  No**

**7.) How many days per week do you exercise? List what type and for how long:**

**8.) How many hours per night do you sleep, on average?**

**9.) Any concerns with your sleeping? If yes, please list .  Yes  No**

## 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**

## 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.