# 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.