

St. Luke's ExecuHealth Pre-Physical Questionnaire

Thank you for choosing St. Luke's ExecuHealth. This questionnaire will help your Lead Physician tailor a comprehensive assessment most appropriate for you, more effectively assess your present and future health concerns, and work with your ExecuHealth Manager to organize a highly efficient experience.

Please complete and submit this form to your ExecuHealth Manager via email or fax to 484-503-0901.

Date of Physical: _____

Full Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Preferred Method of Communication: Phone Email

E-mail Address: _____

Phone Number(s): Please check preferred contact number

Home: _____ Work: _____ Cell: _____

Employer: _____

Title: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Person: _____

Emergency Phone Number: _____ Relationship to Patient: _____

How did you learn about ExecuHealth? TV Billboard Website Print Ad

Referred By: _____ Other: _____

Exercise Clothing: Pants Size: _____ Shirt Size: _____

PRESENT HEALTH STATUS

Please indicate your gender: Male Female

How would you assess your current overall health status?

Excellent Good Fair Poor

How would you describe your health status over the past few years?

Stable Improving Declining

How content are you with your current health status?

Very Content Somewhat Content Disappointed Very Disappointed

Do you have a personal physician? If yes, please provide information below.

Yes No

Physician Name: _____

Physician Address: _____

Physician Phone: _____ Fax: _____

Would you like a copy of your wellness report sent to your physician?

Yes No

MEDICAL HISTORY

Did you have any childhood illnesses which resulted in ongoing abnormalities or may present future health concerns (e.g., Polio with isolated weaknesses; Rheumatic Fever with heart valve damage, etc.)?

Yes No

If yes, please explain: _____

As an adult, have you had a history of any significant medical illnesses, such as:

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Unusual Infections |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Other Illness / Cancer(s) | |

If yes, please explain: _____

Have you been hospitalized for anything other than surgery?

Yes No

If so, for what and when? _____

Please indicate any surgical procedures you have undergone, the surgeon, and when the surgery was performed:

Have you experienced any injuries in the past that compromised any of your functionality?

Yes No

If yes, please explain: _____

Have you had any advanced diagnostic procedures (e.g., heart catheterization, CAT or MRI scans, treadmill studies, etc.)? Yes No

If yes, please indicate the procedure(s), timeframe(s), and reason(s):

Are you able to walk and/or run on a treadmill? Yes No

Please indicate and list all prescription medications, over-the-counter medications, vitamins, and/or herbal supplements you are taking. Include dosages, frequency, and any directions.

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Please indicate the vaccinations you have received and when they were administered:

Pneumonia Hepatitis A / B Tetanus (Td / TdAP Shingles (Zostavax) Influenza

Date: _____

Have you had any travel-related vaccinations (Typhoid, Yellow Fever, etc.)? Yes No

If so, please list these and the date(s) they were administered:

Do you have a history of any food or drug allergies (Iodine, Intravenous Contrast Dye)? Yes No

If yes, please identify the allergy and the reaction you experienced:

Are you allergic or sensitive to any smells, perfumes, lotions, ultrasound gel? Yes No

If yes, please identify the allergy and the reaction you experienced:

FAMILY HISTORY

Father	Mother	Siblings
<p>Is your father living? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Is your mother living? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you have any siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>What age is he (or age at death)? _____ years</p>	<p>What age is she (or age at death)? _____ years</p>	<p>Please specify brother or sister and their age (or age at death)?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Please indicate if your father has (had):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Lung Disease/Emphysema/COPD <input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Serious Infections <input type="checkbox"/> Other Illnesses <p><i>Please provide details:</i></p>	<p>Please indicate if your mother has (had):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Lung Disease/Emphysema/COPD <input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Serious Infections <input type="checkbox"/> Other Illnesses <p><i>Please provide details:</i></p>	<p>Please indicate if your siblings have (had):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Lung Disease/Emphysema/COPD <input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Serious Infections <input type="checkbox"/> Other Illnesses <p><i>Please provide details:</i></p>

SOCIAL HISTORY

Tobacco, Alcohol, Caffeine Use:

Tobacco Use	Alcohol Use	Caffeine / Other Drug Use
<p>Do you currently use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes: What kind (cigarettes, cigars, smokeless)? _____ How many/much do you use daily? _____/day How long? _____ years</p> <p>If no: Have you ever used tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did you quit? _____ What type of tobacco products did you use? _____ How many/much did you use daily? _____/day How long did you use? _____ years Have you been exposed to passive smoking in a household or work environment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long? _____</p>	<p>Do you now drink or have you previously drunk alcohol regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many drinks do you consume daily? _____/day</p> <p>Do you think you have / had a problem with drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you consume caffeine regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many caffeinated drinks do you consume daily? _____/day</p> <p>Do you think you are addicted to caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do/have you:</p> <p><input type="checkbox"/> want to quit?</p> <p><input type="checkbox"/> think you can quit?</p> <p><input type="checkbox"/> ever been able to quit?</p>	<p>Have you:</p> <p><input type="checkbox"/> felt the need to reduce your alcohol consumption?</p> <p><input type="checkbox"/> felt upset by others criticizing your alcohol consumption?</p> <p><input type="checkbox"/> felt guilty about your alcohol consumption?</p> <p><input type="checkbox"/> had the need to drink when you wake in the morning?</p>	<p>Have you ever:</p> <p><input type="checkbox"/> had caffeine withdrawal?</p> <p><input type="checkbox"/> had symptoms such as headache?</p> <p><input type="checkbox"/> used any "recreational" / street drugs?</p> <p><i>If so, please explain:</i></p>

Occupation:

Previous Occupations	Dates of Employment

LIFESTYLE

General:

What is your marital status?

- Married
 Remarried
 Divorced
 Widowed
 Engaged
 Single

Are you satisfied in your current marital state? Yes No

Are there any sexually-related topics that you would like to discuss confidentially? Yes No

Do you have children? Yes No

If yes, please list their birth year, gender and any medical issues:

Are you satisfied with your current work/life balance, lifestyle, and daily responsibilities? Yes No

How would you rate your level of stress?

- Low
 Somewhat Low
 Somewhat High
 Very High

Are you exposed to toxins, irritants, or allergens, etc. at home or work? Yes No

If yes, please explain: _____

How many hours per week are you sedentary? _____

Annually, how much vacation do you typically take? _____

When was your last vacation of one week or more in duration? _____

How long in duration is your longest annual vacation? _____

Exercise:

How do you assess your current state of physical fitness?

- Poor
 Below Average
 Average
 Above Average
 Excellent

Do you partake in a regular exercise program/routine? Yes No

If yes, what type of exercise? _____

If yes, how frequent and long in duration? _____

What are your goals of this exercise program/routine? _____

If no, how long has it been since you exercised? _____

Do you participate in strenuous sports activities (running, biking, etc.)? Yes No

If yes, please describe: _____

Would you like to place greater emphasis on exercise in the future? Yes No

If yes, list any specific goals you would like to achieve: _____

If yes, list areas of your body, if any, for which you would like to focus: _____

Please indicate how much time is available weekly for you to devote to reaching your fitness goals.

Number of sessions/week: _____

Minutes per session: _____

Nutrition:

How would you describe your nutritional diet?

Very Unhealthy Somewhat Unhealthy Somewhat Healthy Very Healthy

Please outline your usual eating schedule and describe what you might eat during the work week:

Time	Description of Meal or Snack

How does what you eat on the weekends differ from the above?

Please indicate how many servings/units you consume per day for the following:

Fruit _____ servings/day
Vegetables _____ servings/day
Proteins _____ servings/day
Desserts _____ servings/day
Sweetened beverages _____ servings/day

On a weekly basis, how often do you eat in restaurants, cafeterias, or away from home?

Breakfast _____ times/week Lunch _____ times/week Dinner _____ times/week

Please describe the type of restaurants where you eat:

Are the people in your life supportive of you eating healthy? Yes No

For any health conditions you may have, which ones do you think may be related to your weight or diet?

Please indicate who prepares your meals: Self Spouse Roommate Other

Are there any special considerations in family meal planning? Yes No

If yes, please describe: _____

Do you note anything that causes you to eat outside of regular meal times or actual hunger?

Yes No

If yes, please describe: _____

What is your usual body weight? _____

What is your desired body weight? _____

Have you experienced any changes in your weight? Yes No

If yes, please explain: _____

What are your dietary goals? _____

SYSTEMS

General:

What are your greatest concerns to your health (stress, sedentary lifestyle, diet, exercise, family history, alcohol, drugs, etc.)?

Head:

Do you suffer from headaches? Yes No

If so, have they been formerly diagnosed (e.g., migraines, tension, cluster, etc.)? Yes No

Please explain: _____

Is your hearing compromised? Yes No

If yes, is there a past history of acoustic trauma, ear disease, or family history of a hearing deficit?

Has your vision changed in the past 1-2 years? Yes No

Have you ever noted temporary changes in your visual fields? (e.g., blind spots) Yes No

If so, which eye, how long, how frequent? _____

Have you had an eye exam within the past two years? Yes No

Do you have a history of allergy symptoms? Yes No

Do you have a history of hoarseness or recurring irregularities of your voice? Yes No

Neck:

Do you have a history of pain or stiffness in your neck? Yes No

If so, are there factors that trigger the pain/stiffness? _____

Do you have a history of swollen glands in the neck? Yes No

If so, are they typically associated with a sore throat or signs of infection? _____

Have you ever experienced thyroid enlargement or tenderness in your neck? Yes No

Lymphatic System:

Do you have history of persistent swollen glands in your neck, underarms, groin or thighs? Yes No

If yes, please describe: _____

Chest:

Have you experienced any of the following:

- Chest Pain Shortness of Breath Cough Chest Congestion
 Wheezing Reduced Tolerance to Exercise

Have you been diagnosed with any of the following:

- Asthma Emphysema COPD

Please provide details: _____

Heart:

Have you ever experienced chest pain caused by:

- Exertion Angina Heart Attack Congestive Heart Failure

If yes, please describe: _____

Have you ever experienced any unusual sensations as a result of physical activity, such as:

- Tightness, Burning, Fullness Other

If yes, please describe: _____

Do you have a history of:

- Skipped Heartbeats Excessively Rapid Heart Rhythm Irregular Heart Rhythm

If yes, please describe: _____

Have you ever passed out? Yes No

If yes, please explain: _____

Have you ever experienced swelling in your legs or ankles? Yes No

If yes, please explain: _____

Have you experienced any pain in your leg muscles when walking that ceases when you halt activity?

- Yes No

Abdomen:

Do you have a history of chronic or persistent:

- Abdominal Pain Indigestion Nausea Vomiting Diarrhea
 Constipation Endoscopy Procedures

If yes, please explain: _____

Do you have a history of:

- Belching Stomach Acid Severe or Persistent 'Heartburn'

If so, please list agitating factors: _____

Have you ever experienced jaundiced skin or noticed dark colored urine? Yes No

Have you noted any change in bowel habits, such as:

- Dark Color and Stature of Stool Straining at defecation
 Continued feeling of needing to clear your bowel after excreting stool

If yes, please explain: _____

Have you or anyone in your immediate family (grandparents, parents, siblings, children) had any of the following conditions?

- Colon Cancer Colon Polyps (malignant or benign) Familial Adenomatous Polyposis
 Other Major Abdominal Disease

If yes, please explain: _____

Have you ever had a Colonoscopy Flexible Sigmoidoscopy Upper Endoscopy (EGD)?

If yes, when and what were the findings?

Genitourinary Tract (Female):

Do you have a history of repeated bladder or urinary tract infections? Yes No

Do you have a history of repeated vaginal infections? Yes No

If so, are they usually triggered by certain factors (e.g., taking antibiotics) Yes No

How many pregnancies have you had? _____

How many were full-term deliveries? _____

How many miscarriages? _____

Did you breast-feed your children?

Yes No

Were you ever informed that you had diabetic predispositions during pregnancy?

Yes No

When was your last Pap smear? _____

Have you ever had an abnormal Pap smear?

Yes No

If so, what actions were taken? _____

When was your last mammogram? _____

Have you ever had a mammogram with abnormal findings?

Yes No

If so, when did this occur? _____

How was this addressed? _____

Have you experienced any indicators of menopause such as "hot flashes", shifts in mood, personality changes?

Yes No

If so, are they currently diminishing, increasing, inactive? _____

Are you now, or in the future, planning to use hormonal replacement therapy to reduce effects of menopausal changes?

Yes No

Have you ever had bone density studies?

Yes No

If yes, what were the results? _____

Extremities:

Do you experience chronic or recurring: Joint Pain Swelling Stiffness Redness

Have you experienced: Muscle Weakness Soreness Loss of Muscle Mass

If yes, please explain: _____

Have you experienced any changes in the fingernails or toenails?

Yes No

If yes, please explain: _____

Do you experience changes in the color or temperature of your hands or feet?

Yes No

Skin:

Do you have any skin lesions that concern you?

Yes No

If yes, please explain: _____

Have you ever had a skin lesion removed?

Yes No

If yes, please explain: _____

Neuropsychiatric:

Have you ever experienced significant anxiety or depression?

Yes No

If yes, please explain: _____

Sleep:

Do you currently have difficulty falling asleep or staying asleep?

Yes No

If yes, please explain: _____

Have you ever been told that you snore significantly?

Yes No

When you wake in the morning, do you feel significantly fatigued?

Yes No

If yes, please explain: _____

Has anyone told you that you stop breathing while asleep?

Yes No

Other Pertinent Medical Information:

Are there other points that you feel should be included in your medical history?

BREAKFAST

<input type="checkbox"/> Scrambled Eggs Whole Wheat Toast Fresh Fruit Cup Bottled Water Decaf Coffee or Decaf Tea	Calories 220 Fat 7 g Saturated Fat 1 g Cholesterol 250 mg Sodium 230 mg	Carbohydrate 20 g Fiber 3 g Sugar 17 g Protein 11 g
<input type="checkbox"/> Oatmeal with Assorted Toppings (dried fruit, nuts, brown sugar) Low Fat Vanilla Yogurt Bottled Water Decaf Coffee or Decaf Tea	Calories 470 Fat 20 g Saturated Fat 2 g Cholesterol 5 mg Sodium 90 mg	Carbohydrate 59 g Fiber 6 g Sugar 62 g Protein 14 g
<input type="checkbox"/> Egg White, Sautéed Spinach and Low Fat Swiss Cheese in a Whole Wheat Tortilla Fresh Fruit Cup Bottled Water Decaf Coffee or Decaf Tea	Calories 452 Fat 13 g Saturated Fat 6 g Cholesterol 20 mg Sodium 750 mg	Carbohydrate 59 g Fiber 9 g Sugar 10 g Protein 23 g

LUNCH

<input type="checkbox"/> Grilled Chicken and Spinach Salad with Strawberries and Mandarin Oranges Fat Free Raspberry Vinaigrette Dressing Whole Wheat Dinner Roll, Margarine Fresh Fruit Cup Bottled Water	Calories 438 Fat 8 g Saturated Fat 1 g Cholesterol 30 mg Sodium 362 mg	Carbohydrate 49 g Fiber 9 g Sugar 37 g Protein 37 g
<input type="checkbox"/> Fresh Ginger Herb Shrimp with Broccoli and Brown Rice Fresh Fruit Cup Bottled Water	Calories 310 Fat 2.5 g Saturated Fat 0 g Cholesterol 120 mg Sodium 575 mg	Carbohydrate 49 g Fiber 5.5 g Sugar 11.5 g Protein 20 g
<input type="checkbox"/> Seasoned Turkey and Avocado in a Whole Wheat Tortilla Organic Lettuce and Tomato Organic Carrot Sticks Fresh Fruit Cup Bottled Water	Calories 503 Fat 14 g Saturated Fat 3.5 g Cholesterol 30 mg Sodium 720 mg	Carbohydrate 55 g Fiber 13.5 g Sugar 17.5 g Protein 13 g

Dietary Restrictions: _____