St Luke's UNIVERSITY HEALTH NETWORK ExecuHealth

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 designated Care Manager to organize a highly efficient experience.

Please complete and submit this form to your Care Manager via fax (484-503-0901).

Name:_____

Home Address:_____

Preferred Method of Communication (circle one)**:** *phone / email*

E-mail Address: _____

Preferred Phone:_____ *(circle one: work / home / cell)*

Occupation:_____

Date of Birth:_____ **S.S.#:**_____

How did you learn about ExecuHealth?_____

Exercise Clothing Preference: *(circle one: shorts / pants)* **Size:** _____ **Shirt Size:**_____

Breakfast Preference: _____

Lunch Preference: _____

Dietary Restrictions: _____

PRESENT HEALTH STATUS

1. What is your current age? _____

2. Please indicate your gender: ❑ Male ❑ Female

3. How would you assess your current overall health status?

   ❑ Excellent ❑ Good ❑ Fair ❑ Poor

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

   ❑ Stable ❑ Improving ❑ Declining

5. How content are you with your current health status?

   ❑ Very content ❑ Somewhat content ❑ Disappointed ❑ Very disappointed

6. Do you have a personal physician? If yes, please provide information below. ❑ Yes ❑ No

   Physician Name_____

   Physician Phone#_____

   Physician Address_____

7. Would you like a copy of your wellness report sent to your physician? ❑ Yes ❑ No

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MEDICAL HISTORY

1. 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: _____

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

Heart Disease	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Lung Disease	❑ Yes	❑ No	Lung Cancer	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No	Unusual Infections	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Emphysema/COPD	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No

   Other Illnesses/Cancer(s) ❑ Yes ❑ No *(If yes, please explain below)*

   _____

   _____

3. Have you been hospitalized for anything other than surgery? ❑ Yes ❑ No

   If so, for what, and when?_____

   _____

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

   _____

   _____

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

   ❑ Yes ❑ No

   If yes, please explain: _____

6. 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):

   _____

   _____

   _____

   _____

7. 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.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking any over-the-counter medications prescribed by your doctor? If yes and not listed above, please list and identify the condition you take them for. ❑ Yes ❑ No

_____

_____

Are you taking any Vitamins or Supplements prescribed by your doctor? If, yes, and not listed above, please list and identify the condition you take them for. ❑ Yes ❑ No

_____

_____

Are you taking any over-the-counter medications or supplements on a regular basis on your own (without direction from your doctor)? If yes, please list and indicate the reason(s) you take them. ❑ Yes ❑ No

_____

_____

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

❑ Pneumonia	❑ Hepatitis A / B	❑ Tetanus (Td / TdAP)	❑ Shingles (Zostavax)	❑ Influenza
Date: _____	_____	_____	_____	_____

9. Have you had any travel-related vaccinations (Typhoid, Yellow Fever, etc.)? If so, please list these and the date(s) they were administered:

_____

10. 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:

_____

Physician notes:

FAMILY HISTORY

Father	Mother	Siblings
Is your father living? ❑ Yes ❑ No	Is your mother living? ❑ Yes ❑ No	Do you have any siblings? ❑ Yes ❑ No
What age is he (or age at death)? _____ years	What age is she (or age at death)? _____years	What age are they (or age at death)? _____ _____ _____
Please indicate if your father has (had): ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses *Please provide details:*	Please indicate if your mother has (had): ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses *Please provide details:*	Please indicated if your siblings have (had): ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses *Please provide details:*

Physician notes:

SOCIAL HISTORY

Tobacco, Alcohol, Caffeine Use:

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

Occupation:

Previous Occupations	Dates of Employment

Physician notes:

LIFESTYLE

General:

1. What is your marital status?
   ❑ Married ❑ Remarried ❑ Divorced ❑ Widowed ❑ Engaged ❑ Single
2. Are you satisfied in your current marital state? ❑ Yes ❑ No
3. Are there any sexually-related topics that you would like to discuss confidentially? ❑ Yes ❑ No

   _____
4. Do you have children? ❑ Yes ❑ No

   If "yes", please list their age(s), gender(s) and any medical issues:

   _____

   _____
5. Are you currently employed? If so, what is your occupation? _____
6. Are you satisfied with your current work/life balance, lifestyle, and daily responsibilities?
   ❑ Yes ❑ No
7. How would you rate your level of stress?

   ❑ Low ❑ Somewhat Low ❑ Somewhat High ❑ Very High
8. Do you have a five-year plan that you perceive as satisfying? ❑ Yes ❑ No
9. At home or work, are you exposed to toxins, irritants, or allergens, etc.? ❑ Yes ❑ No

   If "yes", please explain _____
10. How many hours per week are you sedentary? _____
11. Annually, how much vacation do you typically take? _____
12. When was your last vacation of one week or more in duration? _____
13. How long in duration is your longest annual vacation? _____

Exercise:

1. How do you assess your current state of physical fitness?

   ❑ Poor ❑ Below Average ❑ Average ❑ Above Average ❑ Excellent
2. 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?_____
3. Do you participate in strenuous sports activities (running, biking, etc.)? ❑ Yes ❑ No
   If "yes", please describe: _____

4. 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: _____

   _____

5. 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:

1. How would you describe your nutritional diet?

   ❑ Very unhealthy ❑ Somewhat unhealthy ❑ Somewhat healthy ❑ Very healthy

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

Time	Description of Meal or Snack

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

   _____
   _____

4. 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

5. 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

   If yes, please describe the type of restaurants you typically eat at?

   _____
   _____

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

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

   _____
   _____

7. Please indicate who prepares your meals. ____self ____spouse_____roommate_____ other_____

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

   If yes, please describe: _____
   _____

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

   ❑ Yes ❑ No

   If yes, please describe: _____
   _____

10. What is your usual body weight? _____

11. What is your desired body weight? _____

12. Have you experienced any changes in your weight? ❑ Yes ❑ No

    If yes, please explain: _____
    _____

13. What are your dietary goals?

    _____
    _____

Physician, fitness and nutritional consultants' notes:

SYSTEMS

General:

1. What is your assessment of your overall health?

   _____
   _____

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

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

Head:

1. Do you suffer from headaches? ❑ Yes ❑ No

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

   Please explain:_____

2. 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?

   _____

3. Has your vision changed in the past 1-2 years? ❑ Yes ❑ No
4. Have you ever noted temporary changes in your visual fields? (e.g., blind spots) ❑ Yes ❑ No

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

5. Have you had an eye exam within the past two years? ❑ Yes ❑ No
6. Do you have a history of allergy symptoms? ❑ Yes ❑ No
7. Do you have a history of hoarseness or recurring irregularities of your voice? ❑ Yes ❑ No

Neck:

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

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

2. 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? _____

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

Lymphatic System:

1. Do you have history of persistent swollen glands in your neck, underarms, groin or thighs?
   ❑ Yes ❑ No
   If yes, please describe: _____

Chest:

1. Have you experienced chest pain, shortness of breath, cough, chest congestion, wheezing, reduced tolerance to exercise; or been diagnosed with asthma, emphysema, or COPD? ❑ Yes ❑ No
   If yes, please describe:_____
   _____

Heart:

1. Have you ever experienced chest pain caused by exertion, angina, a heart attack, congestive heart failure, or tightness, burning, fullness, or any other unusual sensations as result of physical activity?
   ❑ Yes ❑ No
   If yes, please describe:_____
   _____
2. Do you have a history of skipped heartbeats, excessively rapid or irregular heart rhythm?
   ❑ Yes ❑ No
   If yes, please describe:_____
   _____
3. Have you ever passed out? ❑ Yes ❑ No
   If yes, please explain:_____
   _____
4. Have you ever experienced swelling in your legs or ankles? ❑ Yes ❑ No
   If yes, please explain:_____
   _____

Abdomen:

1. Do you have a history of chronic or persistent abdominal pain, indigestion, nausea, vomiting, diarrhea, constipation or previous endoscopy procedures? ❑ Yes ❑ No
2. Do you have a history of belching, stomach acid, severe or persistent "heartburn"? ❑ Yes ❑ No
   If so, please list agitating factors: _____
5. Have you ever experienced jaundiced skin or noticed dark colored urine? ❑ Yes ❑ No
6. Have you noted any change in bowel habits, such as color (dark) and stature of stool, straining at defecation, or a continued feeling of needing to clear your bowel after excreting stool?
   ❑ Yes ❑ No
   If yes, please explain:
   _____
   _____

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

Colon Cancer	❑ Yes ❑ No
Colon Polyps (malignant or benign)	❑ Yes ❑ No
Familial Adenomatous Polyposis	❑ Yes ❑ No
Other Major Abdominal Disease	❑ Yes ❑ No

If yes, please explain:_____

8. Have you ever had a colonoscopy, flexible sigmoidoscopy or upper endoscopy (EGD)? ❑ Yes ❑ No

If yes, which procedure did you have, when, and what were the findings?

_____

_____

Genitourinary Tract (Female):

1. Do you have a history of repeated bladder infections? ❑ Yes ❑ No
2. 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
3. How many pregnancies have you had? _____
   How many were full-term deliveries? _____
   How many miscarriages? _____
   Did you breast-feed your children? ❑ Yes ❑ No
4. Were you ever informed that you had diabetic predispositions during pregnancy? ❑ Yes ❑ No
5. Do you have any sexually related questions (e.g., drive, performance)? ❑ Yes ❑ No
6. When was your last Pap smear? _____
   Have you ever had an abnormal Pap smear? ❑ Yes ❑ No
   If so, what actions were taken? _____
7. When was your last mammogram? _____
8. Have you ever had a mammogram with abnormal findings? ❑ Yes ❑ No
   If so, when did this occur? _____
   How was this addressed? _____
9. At approximately what age did your mother begin menopause?_____
   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
10. Have you ever had bone density studies? ❑ Yes ❑ No
    If yes, what were the results? _____
11. Do you current take calcium supplements? ❑ Yes ❑ No
    If so, what kind? _____

Extremities:

1. Do you experience chronic or recurring joint pain, swelling, stiffness, or redness? ❑ Yes ❑ No
2. Have you experienced muscle weakness, soreness, or a loss of muscle mass? ❑ Yes ❑ No

   If yes, please explain: _____
3. Have you experienced any changes in the fingernails or toenails? ❑ Yes ❑ No

   If yes, please explain: _____
4. Have you experienced any pain in your leg muscles when walking that ceases when you halt activity? ❑ Yes ❑ No
5. Do you experience changes in the color or temperature of your hands or feet? ❑ Yes ❑ No

Neuropsychiatric:

1. Do you have a history of motor or sensory abnormalities of any area of the body? ❑ Yes ❑ No
2. Have you ever experienced significant anxiety or depression? ❑ Yes ❑ No
   If yes, please explain: _____
3. Have you ever experienced insomnia or any difficulties with your sleep? ❑ Yes ❑ No
   If yes, please explain: _____

Sleep:

1. Have you ever been told that you snore significantly? ❑ Yes ❑ No
2. When you wake in the morning, do you feel significantly fatigued? ❑ Yes ❑ No
   If yes, please explain: _____
   _____
   _____

Other Pertinent Medical Information:

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

_____
_____
_____
_____
_____
_____

Physician notes: