StLuke'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 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

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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:

- ❑ Heart Disease
- ❑ Lung Disease
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Emphysema/COPD
- ❑ Other Illness / Cancer(s)
- ❑ Diabetes
- ❑ Lung Cancer
- ❑ Unusual Infections
- ❑ Asthma
- ❑ Shortness of Breath

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.

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

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:

____

____

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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	Please specify brother or sister and their age (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 indicate 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:*

SOCIAL HISTORY

Tobacco, Alcohol, Caffeine Use:

Tobacco Use	Alcohol Use	Caffeine / Other Drug Use
Do you currently use tobacco products? ❑ Yes ❑ No **If yes:** What kind (cigarettes, cigars, smokeless)? _________________ How many/much do you use daily? _____________/day How long? _____ years **If no:** 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

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 (Male):

Do you have a history of prostate or bladder infections? ❑ Yes ❑ No

Has a health care professional informed you that you have prostate enlargement? ❑ Yes ❑ No

Is the size and force of your urinary stream smaller or less forceful as compared to when you were 40 years of age (if applicable)? ❑ Yes ❑ No

When sleeping at night, how many times do you wake up to urinate? ______________________

Are you satisfied with your level of sexual performance? ❑ Yes ❑ No

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?

____

____

____

____

____

____

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BREAKFAST

☐ Scrambled Eggs
Whole Wheat Toast
Fresh Fruit Cup
Bottled Water
Decaf Coffee or Decaf Tea

Calories	220	Carbohydrate	20 g
Fat	7 g	Fiber	3 g
Saturated Fat	1 g	Sugar	17 g
Cholesterol	250 mg	Protein	11 g
Sodium	230 mg		

☐ Oatmeal with Assorted Toppings
(dried fruit, nuts, brown sugar)
Low Fat Vanilla Yogurt
Bottled Water
Decaf Coffee or Decaf Tea

Calories	470	Carbohydrate	59 g
Fat	20 g	Fiber	6 g
Saturated Fat	2 g	Sugar	62 g
Cholesterol	5 mg	Protein	14 g
Sodium	90 mg		

☐ 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	Carbohydrate	59 g
Fat	13 g	Fiber	9 g
Saturated Fat	6 g	Sugar	10 g
Cholesterol	20 mg	Protein	23 g
Sodium	750 mg		

LUNCH

☐ 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	Carbohydrate	49 g
Fat	8 g	Fiber	9 g
Saturated Fat	1 g	Sugar	37 g
Cholesterol	30 mg	Protein	37 g
Sodium	362 mg		

☐ Fresh Ginger Herb Shrimp
with Broccoli and Brown Rice
Fresh Fruit Cup
Bottled Water

Calories	310	Carbohydrate	49 g
Fat	2.5 g	Fiber	5.5 g
Saturated Fat	0 g	Sugar	11.5 g
Cholesterol	120 mg	Protein	20 g
Sodium	575 mg		

☐ Seasoned Turkey and Avocado in a Whole
Wheat Tortilla
Organic Lettuce and Tomato
Organic Carrot Sticks
Fresh Fruit Cup
Bottled Water

Calories	503	Carbohydrate	55 g
Fat	14 g	Fiber	13.5 g
Saturated Fat	3.5 g	Sugar	17.5 g
Cholesterol	30 mg	Protein	13 g
Sodium	720 mg		

Dietary Restrictions: ____