# Monsour executive wellness center



#### executive health client questionairre

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

## Contact Information

**What name do you prefer to be called?** Click here to enter text.

**Date of birth:** Click here to enter text. **Gender:** Click here to enter text. **Race:** Click here to enter text.

**Address:** Click here to enter text. **City:** Click here to enter text. **State/Zip:** Click here to enter text.

**Home phone:** Click here to enter text. **Cell:** Click here to enter text.

**E-mail:** Click here to enter text. **Alternate E-mail:** Click here to enter text.

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

**Will your executive physical be paid for by the employer listed above? Yes  No**

**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

**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.

**4.) If you were born between 1945 and 1965 have you been tested for the Hepatitis C antibody?  
 Yes  No  Unsure**The Hepatitis C recommendation is for one time screening of adults born between 1945 and 1965.

**5.) When was your last chest x-ray?** Click here to enter text. **6.) Are you interested in having your chest x-rayed during your executive physical?  Yes  No**

Chestx-rays produce images of your lungs, airways and the bones of your chest. Chest x-rays can also reveal fluid in or around your lungs or air surrounding a lung.  
 **7.) As part of your executive physical, a USF Health Family Medicine/Internal Medicine physician will administer a basic dermatologic skin screening. However, you may elect to have a more thorough skin examination performed in the USF Health Dermatology department? Would you like this service added on? Yes  No   
  
8.) Please list any stressors (physical or psychological) in your life that you would like to discuss with your Executive Health Physician:** Click here to enter text.

## Medical History

**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.  
  
Current prescription medications  
 **Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text.

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**Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text. **Additional medications:** Click here to enter text.Current over the counter medications/herbal products/vitamins  
 **Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text.

**Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text.

**Name:** Click here to enter text. **Dose (strength):** Click here to enter text. **Frequency (daily or as needed):** Click here to enter text.

**PHARMACOGENOMICS**

1. Do you take more than two prescription medications on a daily basis? **Yes  No**
2. Have you ever experienced a bad reaction to a medication causing you to visit the emergency room or be hospitalized? **Yes  No**
3. Do you sometimes experience unwanted side effects from any of your medications? **Yes  No**
4. Do you sometimes feel that your medications are not working? **Yes  No**
5. Are you interested in pharmacogenetic testing to explain your response to current or future medications that you may be prescribed? **Yes  No**

**Common medications influenced by your genetic makeup**

**Cardiology** **Depression**

Clopidogrel (Plavix®) Citalopram (Celexa®)

Warfarin (Coumadin®) Escitalopram (Lexapro®)

Simvastatin (Zocor®) Paroxetine (Paxil®)

Fluvoxamine (Luvox®)

Sertraline (Zoloft®)

Amitriptyline (Elavil®)

**Epilepsy**  **Gastrointestinal disorders**

Carbamazepine (Tegretol®) Mercaptopurine (Purinethol®)

Phenytoin (Dilantin®) Azathioprine (Imuran®)

**Infectious diseases** **Pain Management**

Abacavir (Ziagen®) Codeine (Tylenol #3®)

Voriconazole (Vfend®) Tramadol (Ultram®)

Pegylated interferon

**Oncology**

Fluorouracil (Fluoroplex®)

Capecitabine (Xeloda®)

Surgical History and Hospitalizations  
 **Date of Surgery** Click here to enter text. **Type of Surgery** Click here to enter text.

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Please check if you are bothered by any of these conditions

**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.

**Have you ever had a blood transfusion?  Yes  No**

**If yes, when and why?** Click here to enter text.

**Have you ever had or do you presently have cancer?  Yes  No**

**If yes, please list when and what type of cancer.** Click here to enter text.

**Please list any other chronic medical problems/conditions.** 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.

*Bone fracture probability indicators*

**Weight:** Click here to enter text. **Height:** Click here to enter text.

**Are you between the ages of 40 and 90?  Yes  No   
  
Have you had a previous fracture?  Yes  No  
  
Did one of your parents fracture a hip?  Yes  No  
  
Are you a smoker?  Yes  No  
  
Are you taking glucocorticoids?  Yes  No  
  
Do you have rheumatoid arthritis?  Yes  No  
  
Do you have secondary osteoporosis?  Yes  No   
  
Do you drink more than 3 alcoholic beverages per day?  Yes  No  
  
Have you had a (hip) bone mineral density t-scale competed previously?  Yes  No**

## preventative healthcare

Immunizations and Vaccines   
 **Indicate the last time the following were performed or “never”  
  
Tetanus:** Click here to enter text. **Pneumovax (pneumonia):** Click here to enter text. **Hepatitis A series:** Click here to enter text. **Hepatitis B series:** Click here to enter text. **Zostavax (shingles):** Click here to enter text. **Other vaccinations:** Click here to enter text.

**Have you ever been tested for HIV?  Yes  No**

**If yes, what year?** Click here to enter text.

**Would you like to be tested?  Yes  No**

**Would you like STD panel testing? (Gonorrhea, syphilis, chlamydia)  Yes  No**

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

health maintenance tests  
  
**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.

*If more than 10 months, please bring your mammogram films & reports for a comparative study.* **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

**Birthplace:** Click here to enter text. **Where is your primary home?** Click here to enter text. **Occupation:** Click here to enter text. **Are there or have there been any occupational exposures to chemicals, products, noise or other health risks?   
 Yes  No  
  
If yes, please specify.** Click here to enter text. **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.

**Have you ever had a drinking problem?  Yes  No**

**Have you ever tried cutting down or stopping and were unable?  Yes  No**

**Have you ever gotten annoyed by someone for “harassing” you about your drinking?  Yes  No**

**Have you ever felt guilty about your drinking?  Yes  No**

**Do you occasionally have an “eye opener” to get started on the day?  Yes  No  
  
  
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 and fitness

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

**2.) Please describe any special diet features.** Click here to enter text. **3.) How many cups of coffee, tea, soda or other caffeinated products you drink daily.** Click here to enter text.

**4.) List the total number of waters you drink in a typical day.** Click here to enter text.

Briefly outline your typical diet in an average day  
  
**Breakfast:** Click here to enter text. **Lunch:** Click here to enter text. **Dinner:** Click here to enter text. **Snacks:** Click here to enter text. **Beverages:** Click here to enter text. **5.) Do you consider yourself to be at the appropriate weight?  Yes  No**

**6.) If no, what do you think would be an appropriate weight for you?** Click here to enter text.

**7.) What weight loss diets or plans have you tried in the past year?   
  
 Atkins  South Beach  Weight Watchers  Jenny Craig  Other  
If other, what kind?** Click here to enter text. **8.) On a scale of 1-10 with 0 being the least motivated and 10 being the most motivated, how would you rate your current motivation to make diet changes?** Click here to enter text.

**9.) How many days per week do you exercise?** Click here to enter text.

Outline your typical weekly exercise routine below  
Endurance/Cardiovascular**:  
Type:** Click here to enter text. **Duration:** Click here to enter text. **Frequency:** Click here to enter text.

Strength:  
**Type:** Click here to enter text. **Duration:** Click here to enter text. **Frequency:** Click here to enter text.

Balance:  
**Type:** Click here to enter text. **Duration:** Click here to enter text. **Frequency:** Click here to enter text.

Flexibility:  
**Type:** Click here to enter text. **Duration:** Click here to enter text. **Frequency:** Click here to enter text.

## 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**

**16.) Trouble falling/staying asleep, sleeping too much.  
 None  Several days  More than half the days  Nearly every day**

## sleep questionairre

**1.) On average, How many hours per night do you sleep?** Click here to enter text.

**2.) Do you have trouble falling asleep?  Yes  No**

**3.) Do you have trouble staying asleep?  Yes  No**

**4.) Do you snore?  Yes  No  I don’t know**

**5.) If you snore, how loud is your snoring?   
 My snoring is as loud as breathing  
 My snoring is as loud as talking  
 My snoring is louder than talking  
 My snoring is very loud**

**6.) How frequently do you snore?   
  Almost every day  
  3-4 times per week  
  1-2 times per week  
  1-2 times per month  
  Never or almost never**

**7.) Does your snoring bother other people?  Yes  No**

**8.) Has anyone noticed that you quit breathing during your sleep?   
 Almost every day  
 3-4 times per week  
 1-2 times per week  
 1-2 times per month  
 Never or almost never**

**9.) Are you tired after sleeping?   
 Almost every day  
 3-4 times per week  
 1-2 times per week  
 1-2 times per month  
 Never or almost never**

**10.) Are you tired during wake time?   
 Almost every day  
 3-4 times per week  
 1-2 times per week  
 1-2 times per month  
 Never or almost never**

**11.) Have you ever nodded off or fallen asleep while driving a vehicle?  Yes  No**

**12.) If yes, how often does this occur?   
  Almost every day  
  3-4 times per week  
  1-2 times per week  
  1-2 times per month  
  Never or almost never**

## family history

**1.) Who lives in your home (including pets)?** Click here to enter text.

**2.) Are you married or in a cohabitional relationship?  Yes  No**

**If yes, for how long?** Click here to enter text.

**3.) What is your spouse/partner’s occupation?** Click here to enter text.

**4.) Have you ever been afraid of your spouse/partner?  Yes  No**

**5.) Monogamous (i.e. other partners)?  Yes  No**

**6.) Any sexual concerns?  Yes  No**

**If yes, please list.** Click here to enter text.

**7.) Are you a caregiver for a family member?  Yes  No**

**If yes, briefly describe your role.** Click here to enter text.

**8.) Do you have a “living will” or other advanced directives?  Yes  No**

**If yes, where is it filed?** Click here to enter text.

**If no, would you like information?  Yes  No**

**9.) Were you adopted?  Yes  No  
  
If no, please complete the following table:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Family member | Gender | Age | Living | Deceased | Illnesses\* | Cause of death | General health |
| Father |  |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Spouse/Partner |  |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |  |

## 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.