St Luke's UNIVERSITY HEALTH NETWORK ExecuHealth

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

IMPORTANT - DOCUMENT USAGE INSTRUCTIONS

We highly recommend using Adobe Acrobat Reader (free), or Acrobat Std/Pro, to complete this form. Using a web browser such as Chrome, Edge, Safari, or Firefox is NOT recommended.

Mac Users: Please do not use the application called *"Preview"* installed on Apple computers to complete this form. Instead, use Adobe Acrobat Reader/Std/Pro.

*****If needed, you may download Adobe Acrobat Reader for free here (Windows / Mac)*

Questionnaire and Health History

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.

1 PATIENT INFORMATION

Date of Physical: _____

Full Name: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Home Address: _____ _____ _____ _____
Street Number & Name *(Incl. Apt #, if applicable)* City State Zip Code

Phone Number(s): (Please select your preferred contact number)

☐ Home: _____ ☐ Work: _____ ☐ Cell: _____

Email: _____ **Preferred Method of Communication:** ☐ Phone ☐ Email

Employer: _____ **Title:** _____

Employer Address: _____ _____ _____ _____
City State Zip Code

How did you learn about ExecuHealth? ☐ TV ☐ Billboard ☐ Website ☐ Print Ad ☐ Other: _____

Referred By: _____ **Other:** _____

Exercise Clothing Size: ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ 2X-Large ☐ 3X-Large

2 PRESENT HEALTH STATUS

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.*

Physician Name: _____ **Phone:** _____ **Fax:** _____

Physician Address: _____ _____ _____ _____
City State Zip Code

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

Your ExecuHealth Lead Physician will provide any necessary prescriptions and follow up orders at the conclusion of your physical. If continued care is required, prescription refills and subsequent orders are to be managed by your personal Primary Care Physician.

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

If yes to any of above, please explain:

Have you been hospitalized for anything other than surgery? ☐ Yes ☐ No

If yes, 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/Shingrix) _____
- ☐ Influenza _____
- ☐ COVID 19 _____
- ☐ Other _____
- ☐ Other _____

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

If yes, 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:

3 FAMILY HISTORY

Father

Year of birth *or* age at death: _____

Please indicate if your father has or had:

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Lung Disease/ Emphysema/COPD
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Other Illnesses
- ☐ Serious Infections
- ☐ Cancer
- ☐ Skin Cancer such as Melanoma or Merkel Cell Carcinoma or Pancreatic Cancer
- ☐ Eczema, Asthma, Hay Fever or Seasonal Allergies
- ☐ Psoriasis or Psoriatic Arthritis

Please provide details:

Mother

Year of birth *or* age at death: _____

Please indicate if your mother has or had:

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Lung Disease/ Emphysema/COPD
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Other Illnesses
- ☐ Serious Infections
- ☐ Cancer
- ☐ Skin Cancer such as Melanoma or Merkel Cell Carcinoma or Pancreatic Cancer
- ☐ Eczema, Asthma, Hay Fever or Seasonal Allergies
- ☐ Psoriasis or Psoriatic Arthritis

Please provide details:

Siblings

Please specify brother or sister and Year of birth *or* age at death:

Please provide details:

Please indicate if your siblings have or had:

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Lung Disease/Emphysema/ COPD
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Other Illnesses
- ☐ Serious Infections
- ☐ Cancer
- ☐ Skin Cancer such as Melanoma or Merkel Cell Carcinoma or Pancreatic Cancer
- ☐ Eczema, Asthma, Hay Fever or Seasonal Allergies
- ☐ Psoriasis or Psoriatic Arthritis

4 SOCIAL HISTORY

Tobacco Use

Do you currently use tobacco products? ☐ Yes ☐ No

If yes: What kind (cigarettes, cigars, smokeless)? _____

Frequency of use? _____ 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? _____

Frequency of use? _____ How long? _____ *(years)*

Have you been exposed to passive smoking in a household or work environment? ☐ Yes ☐ No

If yes, how long? _____

Do/have you: ☐ want to quit? ☐ think you can quit? ☐ ever been able to quit?

Alcohol Use

Do you currently consume alcohol on a regular basis? ☐ Yes ☐ No

Have you previously consumed alcohol on a regular basis? ☐ Yes ☐ No

If yes: How many drinks do you consume daily? _____

Do you think you have/had a problem with drinking? ☐ Yes ☐ No

Have you ever...

- felt the need to reduce your alcohol consumption? ☐ Yes ☐ No
- felt upset by others criticizing your alcohol consumption? ☐ Yes ☐ No
- felt guilty about your alcohol consumption? ☐ Yes ☐ No
- had the need to drink when you wake in the morning? ☐ Yes ☐ No

Please Continue on Next Page

Caffeine / Other Drug Use

Do you consume caffeine regularly? ..... ☐ Yes ☐ No

If yes: How many caffeinated drinks do you consume daily? _____

Do you think you are addicted to caffeine? ☐ Yes ☐ No

Have you ever...

- had caffeine withdrawal? ☐ Yes ☐ No
- had symptoms such as headache? ☐ Yes ☐ No
- used any recreational / street drugs? ☐ Yes ☐ No

If yes to either "Have you ever...." question, please explain:

Occupation

Please list your most recent employment history and date of employment (From - To):

Previous Employment/Occupations	Dates of Employment
	-
	-
	-
	-
	-

6 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

If yes, please indicate:

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? _____

How frequently 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 (e.g., 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:

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:

Sessions per 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* Desserts _____ *servings/day*

Vegetables _____ *servings/day* Sweetened beverages _____ *servings/day*

Proteins _____ *servings/day* _____ _____ *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?

7 SYSTEMS

General

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

Head

Do you suffer from headaches? ☐ Yes ☐ No

If yes: 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? ☐ Yes ☐ No

If yes, please explain:

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 yes: 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 yes: Are there factors that trigger the pain/stiffness? ☐ Yes ☐ No

If yes, please explain:

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

If yes: 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
☐ Wheezing ☐ Reduced Tolerance to Exercise ☐ Chest Congestion

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 ☐ Vomiting ☐ Endoscopy Procedures
☐ Constipation ☐ Nausea ☐ Diarrhea

If yes, please explain:

Do you have a history of: ☐ Belching ☐ Stomach Acid ☐ Severe or Persistent 'Heartburn'

If yes, please indicate 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?

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:

Have you ever had or do you currently have any of the following:

☐ Eczema ☐ Psoriasis ☐ HIV/AIDS ☐ Hepatitis B or C ☐ Tuberculosis ☐ Radiation Treatment

☐ Skin Cancer, such as Melanoma, Basal Cell Carcinoma, Squamous Cell Carcinoma

☐ Systemic immunosuppression such as Diabetes, Biologic or Immunotherapy, Chemotherapy, Organ Transplantation, Bone Marrow Transplantation

If yes, please provide details:

Neuropsychiatric

Over the last 2 weeks, how often have you been bothered by the following problems:

	Not at All	Several Days	More than Half of Days	Nearly Every Day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

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

Has anyone told you that you stop breathing while asleep? ☐ Yes ☐ No

Please Continue on Next Page

MALE Genitourinary Tract

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

FEMALE Genitourinary Tract

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 yes, 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 yes, 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?

8 OTHER PERTINENT MEDICAL INFORMATION

Are there other points that you feel should be included in your medical history? ☐ Yes ☐ No

If yes, please indicate/explain:

Thank you for taking the time to complete this questionnaire.
Please review and ensure you've answered all questions and sections appropriately.

Please submit this questionnaire, along with your menu (separate attachment), to ExecuHealth via email or fax to (484) 503-0901