Comprehensive Physical Examination

Medical Questionnaire

Patient Name:
Date:

The EXECUTIVE EVALUATION CENTER
A division of SMG Innovations, Inc.

Welcome to the Sentara Executive Evaluation Center. Today, in an effort to offer you the greatest opportunity for a long and productive life, you will receive what we believe to be the most comprehensive health evaluation available in this country. The following questionnaire will assist your physician in formulating a comprehensive medical history that we will keep current over the years as you return for annual re-evaluations. You will note that it may be more thorough than other medical forms that you have previously completed, but the additional information will allow your physician to more effectively assess your present and future health concerns. Your responses will be reviewed with you by your physician during your comprehensive evaluation.

A) PRESENT HEALTH STATUS

1. What is your present age? _____
2. What is your gender: ❑ Male ❑ Female
3. How do you assess your present overall health status? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
4. What has been the pattern of your health picture over the past few years?
   ❑ Stable ❑ Improving ❑ Declining
5. How content are you with your present general health?
   ❑ Very content ❑ Somewhat content ❑ Disappointed in present health
6. Do you have a personal physician? ❑ Yes ❑ No

If yes: Physician Name_____ Physician Phone#_____

Physician Location_____

7. Would you like a copy of your report to be sent to your physician ❑ Yes ❑ No
8. Are you interested in learning more about the Dedicated Care Center, our membership-based concierge medical practice? ❑ Yes ❑ No

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B) PAST MEDICAL HISTORY

1. Did you have any unusual childhood illnesses that left you with either residual abnormalities or health concerns for the future? (i.e. 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 at any time in the past? ❑ Yes ❑ No

If so, for what, and when?

_____

_____

4. What surgical procedures have you undergone in the past, who was your surgeon and when was surgery performed?

_____

_____

_____

5. Is there a history of injury in the past that left you with any compromise of function? ❑ Yes ❑ No

If yes, please explain: _____

6. Have you had any specialized diagnostic procedures in the past? (i.e. heart catheterization, CAT or MRI scans, treadmill studies, etc.) ❑ Yes ❑ No If yes, please explain below (with date(s)):

_____

_____

8) Please list all medications you are taking (including prescription, herbal and over-the-counter medications)? Please make sure to list EVERY medication, including dosages, and directions.

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

Are you taking Aspirin 81 mg daily? ❑ Yes ❑ No

Are you taking Vitamin E daily? ❑ Yes ❑ No

Are you taking Folbee or a folic acid/Vitamin B-12 supplement? ❑ Yes ❑ No

9. Please check the vaccinations you have had and list when you received them:

❑ Pneumovax ❑ Hepatitis A / B series ❑ Tetanus (Td / TdAP) ❑ Shingles (Zostavax) ❑ Influenza

Date: _____ _____ _____ _____ _____

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

_____

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11. Do you have a history of drug or food allergies? ❑ Yes ❑ No

If yes, please list these below and the reaction you experienced:

_____

12. **Are you allergic to Iodine, Seafood, or Intravenous Contrast Dye?** ❑ Yes ❑ No

C) FAMILY HISTORY

Father	**Mother**	**Siblings**
Is your father living? ❑ Yes ❑ No	Is your mother living? ❑ Yes ❑ No	Are any siblings deceased? ❑ Yes ❑No
How old is he (or age at death)? _____	How old is she (or age at death)? ____	How old are they (or age at death)? _____
Does / did your father have any of the following medical problems? ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses *Please provide details:*	Does / did your mother have any of the following medical problems? ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses: *Please provide details:*	Do / did your siblings have any of the following medical problems? ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses: *Please provide details:*

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D) SOCIAL HISTORY

Tobacco Use	Alcohol Use	Caffeine / other Drug Use
Do you now or have you previously smoked or use tobacco products? ❑ Yes ❑ No	Do you now drink or have your previously drunk alcohol regularly? ❑ Yes ❑ No	Do you ingest caffeine regularly? ❑ Yes ❑No
How many cigarettes do you smoke daily? _____/day	How many drinks do you drink daily? _____/day	How many caffeinated drinks do you drink daily? _____/day
For how many years did you / have you been smoking _____ years	Do you think you have / had a problem with drinking? ❑ Yes ❑ No	Do you think you are addicted to caffeine? ❑ Yes ❑ No
Do you / Have you: ❑ ever use other forms of tobacco products? ❑ want to quit? ❑ Think you can quit? ❑ ever been able to quit?	Have you ever: ❑ felt the need to cut down on your drinking? ❑ felt annoyed by others criticizing your drinking ❑ ever felt guilty about drinking? ❑ ever felt the need for a drink first thing in the morning?	Do you / have you ever: ❑ had caffeine withdrawal symptoms such as headache ❑ used any recreational / street drugs? If so, please list them:

Family / Work / Fitness

1. What is your marital status?

   ❑ married ❑ remarried ❑ divorced ❑ widowed ❑ engaged ❑ single

2. Are you satisfied in your present marital state? ❑ Yes ❑ No

3. Are there topics that you would like to discuss in complete confidence regarding your social or sexual life? (HIV testing, etc.) ❑ Yes ❑ No

4. Do you have children? ❑ Yes ❑ No

   If yes , please list their ages, genders and any medical problems they have:

   _____

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_____

5. Are you employed? If so, in what capacity? _____

6. Are you satisfied with your present lifestyle and daily responsibilities? ❑ Yes ❑ No

7. Are your stress levels acceptable to you? ❑ Yes ❑ No

8. Do you have plans for five years into the future that seem fulfilling? ❑ Yes ❑ No

9. Are you exposed to toxins, irritants, allergens, etc. in your employment or home? ❑ Yes ❑ No

If yes , please indicate how and when _____

10. How many hours per week do you devote to sedentary activities? _____

11. How much vacation do you take in an average year? _____

12. When was your last vacation of one week or more? _____

13. What is the approximate length of your longest annual vacation? _____

14. What is your assessment of your present state of physical fitness?

❑ Poor ❑ Below Average ❑ Average ❑ Above Average ❑ Excellent

15. Do you have a regular exercise program? ❑ Yes ❑ No

If so, what is it? _____

16. Do you participate in strenuous sports activities? (Tennis, swimming, running etc.) ❑ Yes ❑ No

If yes , what activities: _____

17. Are you aware of the association of improved longevity with regular exercise? ❑ Yes ❑ No

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E) REVIEW OF SYSTEMS

(If you answer Yes to any of these questions, please provide further details in the spa ce below each question:

General:

1. How would you assess your overall health picture?

_____

_____

2. What are the weakest points of your overall health? (Smoking, alcohol, stress, sedentary lifestyle, family history, etc.)

_____

Head:

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

If so, have they been "labeled"(i.e. migraines, tension, cluster, etc.) ❑ Yes ❑ No

_____

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. Have there been any changes in your vision in the past 1-2 years? ❑ Yes ❑ No

4. Have you ever noted transient changes in your visual fields? (i.e. "blind spots") ❑ Yes ❑ No
If so, in which eye and for how long?

_____

4. Have you had an eye examination within the past two years? ❑ Yes ❑ No

5. Do you have a history of allergic symptoms? (sniffling, nasal congestion, etc.) ❑ Yes ❑ No

6. Do you have a history of hoarseness, or other recurrent abnormalities of voice? ❑ Yes ❑ No

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Neck:

1. Is there a history of neck pain or stiffness? ❑ Yes ❑ No

   If so, are there provoking factors? _____

2. Is there a history of swollen glands in the neck? ❑ Yes ❑ No

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

3. Is there any history of thyroid enlargement (goiter), or neck tenderness? ❑ Yes ❑ No

Lymphatic System:

1. Is there any history of persistent swollen glands of the neck, underarms, groin or thighs? ❑ Yes ❑ No

   If yes, please describe: _____

Chest:

1. Is there any history of chest pain, shortness of breath, asthma, emphysema, COPD, cough, chest congestion wheezing, or diminished exercise tolerance? ❑ Yes ❑ No

_____

_____

Heart:

1. Is there any history of exertional chest pain, angina, heart attack, congestive heart failure, tightness, burning, fullness, or any other unusual sensations noted with activity? ❑ Yes ❑ No

_____

_____

2. Is there a history of skipped heartbeats, inappropriately rapid or irregular heart rhythm? ❑ Yes ❑ No

_____

Abdomen:

1. Is there any history of chronic or recurrent abdominal pain, indigestion, nausea, vomiting, diarrhea, constipation or previous endoscopy procedures? ❑ Yes ❑ No

2. Is there a history of belching of stomach acid, severe or recurrent "heartburn" ❑ Yes ❑ No

   If so, please list provoking factors: _____

3. Have you ever noted jaundiced skin or Coca-Cola colored urine? ❑ Yes ❑ No

3. Have you noted any change in bowel habits, such as dark stool s, diminished caliber of the stool, straining at defecation, or a persistent feeling of the need to evacuate the bowel unrelieved by passage of stool? ❑ Yes ❑ No

_____

5. Have you or anyone in your immediate family (parents, grandparents, children, siblings) ever 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 specify_____

_____

6. Have you had prior colonoscopy, flexible sigmoidoscopy or upper endoscopy (EGD)? an in and an in and an in and an in and an in and a you and an in and in a you and an in and ❑ Yes ❑ No

If yes, when did you have it and what did it show? _____

_____

Genitourinary Tract:

1. Is there a history of bladder or prostate infections? ❑ Yes ❑ No

2. Have you been told of prostate enlargement in the past? ❑ Yes ❑ No

3. Do you have a history of diminished size and force of the urinary stream as compared to that of age forty? ❑ Yes ❑ No

4. Is your sexual performance adequate? ❑ Yes ❑ No

5. Is there is a problem that would justify further investigation? ❑ Yes ❑ No

Extremities:

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1. Is there a history of chronic or recurrent joint pain, swelling, stiffness or redness. ❑ Yes ❑ No
2. Is there a history of muscle weakness, tenderness or loss of muscle mass? ❑ Yes ❑ No
3. Is there a history of unexpected changes in the fingernails or toenails? ❑ Yes ❑ No
4. Is there a history of pain in the muscles of the legs with walking that quickly clears with cessation of activity? ❑ Yes ❑ No
5. Is there a history of color or temperature changes of the hands or feet? ❑ Yes ❑ No

Central Nervous System:

1. Is there a history of motor or sensory abnormalities of any area of the body? ❑ Yes ❑ No
2. Is there a history of unusual levels of anxiety or depression? ❑ Yes ❑ No

Other Pertinent Medical Information:

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

_____

_____

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

*NAME:*_____

*HOME ADDRESS:*_____

E-MAIL ADDRESS: _____

*HOME PHONE:*_____ *WORK PHONE:*_____

*OCCUPATION:*_____

*DATE OF BIRTH:*_____ *S.S.#:*_____

*HOW DID YOU HEAR ABOUT OUR CENTER?*_____

_____