Cleveland Clinic

Executive Health

# Medical History

Date: ____/____/____

**Please email back to ExecutiveHealthPSS@ccf.org before your scheduled Executive Health exam.**
**Do not mail. BRING ORIGINAL WITH YOU ON DAY OF EXAM**

Name _____ Clinic # _____
(Last) (First) (Middle)

Home Address _____
(Street) (City) (State) (Zip)

Home Phone (____)_____ Business Phone (____) _____ Ext. _____

Cell Phone (____) _____ Email Address _____

Employer _____ Job Title/Occupation _____

Age _____ DOB _____ Place of Birth _____ Education (highest level attained) _____

Marital/Relationship Status_____ Name _____

Personal Physician _____ Address _____
(Street) (City) (State) (Zip)

**Current symptoms or problems you would like evaluated?**

1. _____ 3. _____
2. _____ 4. _____

**Known medical conditions you have or are being treated for, or updates since your last Executive Physical.**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

**Operations or procedures (including vasectomy, LASIK, tonsillectomy) or updates since your last Executive Physical.**

1. _____ Date _____ 4. _____ Date _____
2. _____ Date _____ 5. _____ Date _____
3. _____ Date _____ 6. _____ Date _____

**Date of your last colonscopy:** _____ **Advised interval for follow up:** _____

**Medications:** List all prescription medicines that you have been taking recently. Please bring all medicines with you or photos of the prescription labels. Name, dose (strength & times per day) and date started:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

**List all non-prescription medications such as aspirin, pain medications, vitamins, sleep aids and supplements you are taking:**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

**Allergies or reactions to medicines or other substances.** Name of medication and type of reaction:

1. _____ 3. _____
2. _____ 4. _____

**Immunization History** (bring records with you)

**COVID:** Brand_____ Dates _____; _____; _____; _____

**Hepatitis A:** _____; _____**Hepatitis B:** _____; _____; _____

**Influenza:** _____

**Tetanus/Diphtheria/Pertussis** (TDAP): _____ **Tetanus/Diphtheria booster:** _____

**Pneumococcal:** Prevnar (PCV – 13/20) _____ Pneumovax 23 _____

**Shingrix:** (herpes zoster/shingles) _____; _____

**Other:** _____

**Family History:** List parents, all natural brothers, sisters and children. If deceased, list age at death.

| | **Living** | **Age(s)** | **Known serious medical conditions or cause of death** |
|---|---|---|---|
| Mother | ☐ Yes ☐ No | _____ | _____ |
| Father | ☐ Yes ☐ No | _____ | _____ |
| Sisters | ☐ Yes ☐ No | _____ | _____ |
| Brothers | ☐ Yes ☐ No | _____ | _____ |
| Children | ☐ Yes ☐ No | _____ | _____ |

**Is there a family history of any of the following in a blood relative, including parents, sisters, brothers, grandparents, aunts, uncles, etc?**

- ☐ Heart Attack/Angioplasty/Heart
- ☐ High Blood Pressure
- ☐ High Cholesterol/Triglycerides
- ☐ Diabetes
- ☐ Stroke
- ☐ Brain Aneurysm
- ☐ Aortic Aneurysm
- ☐ Blood Clots
- ☐ Asthma
- ☐ Emphysema
- ☐ Liver Disease
- ☐ Hemochromatosis
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Epilepsy (Seizures)
- ☐ Migraine Headaches
- ☐ Blindness
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Mental Health Disease
- ☐ Alcoholism
- ☐ Colon Polyps
- ☐ Colon Cancer
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Other Cancer _____
- ☐ Other Problems _____

**Lifestyle Habits**

☐ Yes ☐ No Do you use tobacco?
_____ packs of cigarettes/week _____ cigars/week
_____ pouches or tins/week _____ vaping cartridges or pens/week
_____ total years smoking

When did you quit cigarettes or other tobacco?

☐ Yes ☐ No Did you previously smoke? Total years smoking _____ Packs/day _____

☐ Yes ☐ No Does someone in your household smoke?

☐ Yes ☐ No Do you wear a seatbelt whenever in the car?

☐ Yes ☐ No Do you wear a helmet while on a bicycle or motorcycle?

☐ Yes ☐ No Do you use wearable health technology?

☐ Yes ☐ No Do you feel that technological devices have had a negative effect on your health?

☐ Yes ☐ No Do you consume alcohol? If so:
Liquor _____ drinks/day or week (circle one) (1 drink = 1.5 oz liquor)
Wine _____ glasses/day or week (circle one) (1 glass wine = 5 oz wine)
Beer _____ bottles or glasses/day or week (circle one)
(1 bottle or glass beer = 12 oz)

☐ Yes ☐ No Do you drink coffee or tea? If so:
caffeinated _____ cups/day or week (circle one)
decaffeinated _____ cups/day or week (circle one)

☐ Yes ☐ No Do you add sugar substitute, creamer or milk?

☐ Yes ☐ No Do you drink caffeinated soda? If so:
_____ ounces/day or week (circle one) ☐ Diet or ☐ Regular

**General**

☐ Yes ☐ No In general do you feel well?

☐ Yes ☐ No Have you had unusual fatigue?

☐ Yes ☐ No Have you had unexpected weight loss or loss of appetite?

☐ Yes ☐ No Have you had recent fever, chills or night sweats?

## Head and Neck

☐ Yes ☐ No Do you have frequent or periodic headaches?
☐ Yes ☐ No Does your vision blur, do you see double or do you see haloes around lights?
☐ Yes ☐ No Have you had an eye exam in the last year?
☐ Yes ☐ No Have you even been told you have glaucoma or another eye disease?
☐ Yes ☐ No Do you have ringing in the ears?
☐ Yes ☐ No Have you or your family noticed your hearing has changed?
☐ Yes ☐ No Do you wear a hearing aid?
☐ Yes ☐ No Do you have environmental allergies?
☐ Yes ☐ No Do you regularly have dental exams?

## Cardiopulmonary

☐ Yes ☐ No Do you have asthma or COPD?
☐ Yes ☐ No Do you have a chronic cough or unusual shortness of breath?
☐ Yes ☐ No Have you had heart trouble?
☐ Yes ☐ No Do you notice chest pain, discomfort, or tightness? If so:
a. How long does it last? _____
b. Is it caused by exertion? ☐ Yes ☐ No
c. Is it related to sleep, cold air, emotional stress or food ingestion? ☐ Yes ☐ No
☐ Yes ☐ No Do you notice an irregular or rapid heart beat? If so, when this occurs have you become lightheaded, had chest pain, or lost consciousness? ☐ Yes ☐ No
☐ Yes ☐ No Have you noticed muscle pain in your legs (thighs/calves) when walking? If so does it leave immediately with rest? ☐ Yes ☐ No
☐ Yes ☐ No Have you noticed swelling of the feet, ankles or hands?
☐ Yes ☐ No Have you had a stress test, echocardiogram or heart catheterization? (If done outside of Cleveland Clinic, please bring the report with you)
☐ Yes ☐ No Have you had ultrasound of the abdominal aorta and/or of the carotid arteries?
☐ Yes ☐ No Have you been told you have an aortic aneurysm?
☐ Yes ☐ No Have you been told that you have carotid artery disease?

## Gastrointestinal

☐ Yes ☐ No Have you had trouble swallowing?
☐ Yes ☐ No Do you have heartburn or acid reflux?
☐ Yes ☐ No Have you ever had an ulcer? If so, when? _____
☐ Yes ☐ No Are you bothered with recurrent abdominal pain? If yes: ☐ upper ☐ lower ☐ right ☐ left
☐ Yes ☐ No Have you had hepatitis, fatty liver or abnormal liver tests?
☐ Yes ☐ No Have you had a recent change in bowel habits or problems with diarrhea or constipation?
☐ Yes ☐ No Have you had black or tarry appearing stools?
☐ Yes ☐ No Have you had rectal bleeding, blood with your stool, or blood on toilet paper?
☐ Yes ☐ No Do you have hemorrhoids?
☐ Yes ☐ No Have you had a colon polyp or cancer?
☐ Yes ☐ No Has anyone in your family had cancer of the colon?
If yes, specify family member(s) and at what age they were diagnosed? _____

**Urinary**

☐ Yes ☐ No Do you get up at night to urinate? If so, how many times per night? _____

☐ Yes ☐ No Have you had a kidney, bladder or prostate infection in the past year?

☐ Yes ☐ No Have you been bothered with burning on urination?

☐ Yes ☐ No Have you had problems with leaking of urine?

☐ Yes ☐ No Have you had problems emptying your bladder completely?

☐ Yes ☐ No Have you noticed blood in your urine?

☐ Yes ☐ No Have you had kidney stones? If yes, when? _____

**Females**

☐ Yes ☐ No Do you have any vaginal problems or symptoms?

☐ Yes ☐ No Do you have any breast tenderness or nipple discharge?

☐ Yes ☐ No Is premenstrual tension a problem for you?

☐ Yes ☐ No If having menstrual periods, have they changed recently?
How many days are in your menstrual cycle? _____
How many days do you flow? _____
How many pads or tampons do you use on the heaviest day of the flow? _____
Age of onset of menstrual periods _____

☐ Yes ☐ No If postmenopausal, are you having vaginal spotting or bleeding?

☐ Yes ☐ No Are you having problems with hot flashes?

Date of last menstrual period _____

Date of last mammogram _____ Result _____

Date of last Pap smear _____ Result _____

Date of last bone density _____ Result _____

Age at first full term pregnancy _____ Number of live births _____

**Males**

☐ Yes ☐ No When was your last PSA? _____

☐ Yes ☐ No Has your PSA (prostate specific antigen) blood test been elevated?

☐ Yes ☐ No Have you had a prostate biopsy or prostate MRI?

☐ Yes ☐ No Do you have trouble getting an erection?

☐ Yes ☐ No Do you have trouble maintaining an erection?

☐ Yes ☐ No Have you had a significant decrease in sex drive/libido?

☐ Yes ☐ No Have you had significant loss of muscle mass?

☐ Yes ☐ No Do you have significant fatigue?

☐ Yes ☐ No Have you had a decrease in facial hair growth?

**Hematologic**

☐ Yes ☐ No Have you donated blood? Date of last donation _____

☐ Yes ☐ No Have you had a blood clot such as DVT or pulmonary embolism?

☐ Yes ☐ No Have you had anemia?

☐ Yes ☐ No Have you had unusual bleeding or bruising?

☐ Yes ☐ No Have you ever had a blood transfusion? If so, when? _____

**Musculoskeletal**

☐ Yes ☐ No Have you noticed loss of muscle mass?

☐ Yes ☐ No Do you have problems with back pain?
If so, does it go down into the buttock, thigh, calf or foot? ☐ Yes ☐ No

☐ Yes ☐ No Do you have joint pain? If so, which joint? _____

☐ Yes ☐ No Do you have muscle pain or cramps?

☐ Yes ☐ No Do you have neck pain? When? _____

☐ Yes ☐ No Have you had fractures as an adult?
Which bone? _____ Approximate Date _____

**Neurological**

☐ Yes ☐ No Have you had a stroke or temporary symptoms of a stroke?

☐ Yes ☐ No Do you or your family members have significant concerns about you memory?

☐ Yes ☐ No Do you experience numbness or tingling?

☐ Yes ☐ No Do you have frequent or periodic headaches?

☐ Yes ☐ No Do you lose your balance or fall?

☐ Yes ☐ No Have you had or been treated for vertigo?

☐ Yes ☐ No Have you had seizures or convulsions as an adult? If so, when? _____

**Sleep Habits**

☐ Yes ☐ No Have you had a problem with sleep? If yes:
a. Problem falling asleep? ☐ Yes ☐ No
b. Problem awakening mid sleep? ☐ Yes ☐ No
c. Problem in early morning awakening and not able to return to sleep? ☐ Yes ☐ No
On average how many hours of sleep do you get a night? _____

☐ Yes ☐ No Do you feel refreshed when you awaken in the morning?

☐ Yes ☐ No Do you often feel tired or sleepy during the daytime?

☐ Yes ☐ No Do you snore loudly? (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)

☐ Yes ☐ No Has anyone observed you stop breathing or choking/gasping during your sleep?

☐ Yes ☐ No Have you been diagnosed with sleep apena?
If so, what treatment do you use? _____

**Behavioral**

☐ Yes ☐ No Have you had significant stress recently?
☐ Yes ☐ No Have you had significant sadness or depression recently?
☐ Yes ☐ No Are you frequently, angry, nervous or anxious?
☐ Yes ☐ No Are you frequently irritable or short tempered?
☐ Yes ☐ No Major life change events in the past year?
☐ Yes ☐ No Have family members experienced major stress in the past few years?
☐ Yes ☐ No Have you had loss of friends or family in the past few years?
☐ Yes ☐ No Have you ever needed professional help for alcohol, drugs or mental health?
☐ Yes ☐ No Do you have concern about physical or emotional abuse?

**Dermatological**

☐ Yes ☐ No Have you had a full skin exam in the last year?
☐ Yes ☐ No Have you had skin disease or skin cancer?
☐ Yes ☐ No Are any moles getting larger or changing color?
☐ Yes ☐ No Do you have any problem with skin rashes?
☐ Yes ☐ No Do you have any lumps in your skin of concern to you?

**Nutrition**

☐ Yes ☐ No Are you at a weight that you want to be?
If no, what do you think would be a healthy, realistic weight for you? _____ lbs.

How has your weight changed over the past year? ☐ No change _____ # gain _____ # lost

What weight loss diets or programs have you tried in the past?
☐ Atkins/Keto ☐ South Beach/Low-carb/Paleo ☐ Weight Watchers ☐ Jenny Craig
☐ Intermittent Fasting ☐ Other _____

On a scale of 0-10 with 0 being the least motivated and 10 being the most motivated, how would you rate your current motivation to make diet changes? _____

What is your #1 nutrition/diet concern and how can the dietitian help you meet your need? _____
_____

Who does the majority of cooking for your family? ☐ You ☐ Spouse ☐ Other _____

Who does the majority of the grocery shopping for your family? ☐ You ☐ Spouse ☐ Other _____

Average number of meals (breakfast, lunch and dinner) in restaurants, carry-out/delivered, a week: _____

☐ Yes ☐ No Do you read food labels?

How many servings do you have from the dairy group/day? _____
(A serving is 8 oz milk/yogurt or milk alternatives, ½ cup cottage cheese, 1 oz cheese, 1 cup yogurt)

How many servings do you have from the vegetable group/day? _____
(A serving is 2 cups salad, ½ cup cooked vegetables, 1 cup raw vegetables or 6 oz vegetable juice)

How many servings of fruit do you eat/day? _____

(A serving is 1 piece fruit, 6 oz juice, 4 tablespoons dried fruit, 1 cup fresh fruit, ½ cup canned fruit)

How many serving of whole grains do you have daily? _____

(A serving is 1 slice whole grain bread, ½ cup brown rice/quinoa/whole grain pasta, ¾ cup whole-grain cereal, 3 cups popcorn, etc)

Do you drink regular soda/pop, sweetened iced tea, sports drinks or other sweetened beverages?

☐ Yes ☐ No If yes, cans/bottles a day: _____

How many glasses/bottles of water do you drink per day? _____

How many times per week do you eat: fish? _____ red meat (includes pork)? _____

**Exercise/Activity**

☐ Yes ☐ No Do you have a regular exercise program? If so, what activity and frequency?

Cardiovascular Type _____

Frequency _____ times/week

Duration _____ minutes

Strength Type _____

Frequency _____ times/week

Duration _____ minutes

Flexibility Type _____

Frequency _____ times/week

Duration _____ minutes

Sport Type _____

Frequency _____ times/week

Duration _____ minutes

How many flights of stairs can you walk up before you are too winded to continue? _____

What level of activity do you have at work? ☐ Sedentary ☐ Somewhat Active ☐ Active ☐ Very Active

Aside from exercise, what level of activity do you have at home?

☐ Sedentary ☐ Somewhat Active ☐ Active ☐ Very Active

☐ Yes ☐ No Do you have any exercise equipment available to you?

If so, what? _____

☐ Yes ☐ No Have you been instructed to limit your exercise?

And, if so, how? _____

**Work**

☐ Yes ☐ No Number of work hrs/week _____

Percent of time you travel _____% Travel to developing countries? ☐ Yes ☐ No

☐ Yes ☐ No Have you had recent travel to countries experiencing outbreaks of infectious diseases or natural disasters?

What is your primary work location? ☐ Home ☐ Office ☐ Hybrid

Do you feel you manage stress effectively? ☐ No ☐ Most of the time ☐ Yes

External stress level at work: ☐ Mild ☐ Moderate ☐ Heavy ☐ Very Heavy

Internal stress level: ☐ Mild ☐ Moderate ☐ Heavy ☐ Very Heavy

What do you do for stress reduction? _____

☐ Yes ☐ No Are you considering retirement in the next year?

☐ Yes ☐ No Are you considering retirement some time in the near future?

List any other health issues or symptoms you wish to discuss or address:

_____

_____

_____

_____

_____

List any other appointments at Cleveland Clinic you wish to coordinate with your Executive Physical. Specify department and physician. Depending on availability this may require you spend one or two extra days, or to schedule these at a future date.

_____

_____

_____

_____

_____