



**Cleveland Clinic Canada**

## Executive Health Questionnaire (Returning Patient)

Toronto Health and Wellness Centre  
Brookfield Place, Suite 3000  
181 Bay Street, PO Box 818  
Toronto, Ontario M5J 2T3  
Tel: (416) 507-6600 Fax: (416) 507-6610

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## Executive Health Questionnaire

**PLEASE FAX THIS COMPLETED REPORT  
TO THE CONFIDENTIAL FAX MACHINE 416 507-6610**

**MRN #**

Last Name		First Name		Middle Name	OHIP #		Version code	
Home Address					<input type="checkbox"/> Home or <input type="checkbox"/> Cell Phone (include area code)			
City		Prov./State		Postal Code		Business Phone		Ext.
Email				Preferred Contact # <input type="checkbox"/> Home/Cell <input type="checkbox"/> Business		Confidential voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Birth (Month, Date, Year)			Age					
Employer			Occupation/Title					
Emergency Contact			Relationship		Emergency Contact Number:			

Physicians and Allied Health Professionals (Please list other specialty physicians you may have.)			
Name	Specialty	Phone	Fax
	Family Doctor		

Current Health Problems (Please bring medical documents and recent test results with you on the day of your physical exam)	Date of Onset
1.	
2.	
3.	
4.	

Past Medical History	Date
1.	
2.	
3.	
4.	

Past Surgical History and Injuries	Date
1.	
2.	
3.	
4.	

Medications and Supplements (List all prescription and supplements) PLEASE BRING ALL YOUR MEDICINES TO APPOINTMENT					
Name	Dosage	Frequency	Name	Dosage	Frequency
1. <i>Example: ASA</i>	<i>80 mg.</i>	<i>1 tablet daily</i>	5.		
2.			6.		
3.			7.		
4.			8.		

<b>Allergies</b>	
Medications, Foods, Substances or Allergens	Type of reaction
1.	
2.	
3.	
4.	

  

<b>Radiographical Studies</b> Record the date of your last order.			
	Date (MM/DD/YYYY)		Date MM/DD/YYYY
<input type="checkbox"/> General X-ray		<input type="checkbox"/> Ultrasound (list area)	
<input type="checkbox"/> Chest X-ray		<input type="checkbox"/> Colonoscopy	
<input type="checkbox"/> Mammogram		<input type="checkbox"/> Gastroscopy	
Please indicate the location of your last mammogram exam, if applicable.		<input type="checkbox"/> Bone Density	
		<input type="checkbox"/> Others	

  

<b>Laboratory Tests</b> Record the date of your last order.			
	Date		Date
<input type="checkbox"/> PAP		Last menstrual period:	

  

<b>Vision Health</b>	
Do you currently wear any glasses and or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had any corrective eye surgery? If yes, when? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever completed an eye exam with an eye care professional? If yes, when was the last exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	

  

<b>Family History</b> (Please indicate which of your blood relatives have or had the medical conditions noted and the age at death if available)								
CONDITION	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister
<b>Alive or Deceased</b>								
<b>Age</b>								
Alcohol/Drug abuse								
Alzheimer's Disease								
Angina								
Asthma								
Blood Disease								
Breast Cancer								
Colorectal Cancer								
Coronary Artery Disease								
Diabetes Types I or II								
Osteoporosis								
Emphysema								
Heart Attack								
Hypertension								
Lipids								
Ovarian Cancer								
Prostate Cancer								
Stroke								
Thyroid disease								
Other cancer								

  

<b>Details</b>

**Lifestyle Health Behaviours**

**Tobacco Use:**

Yes  No  Do you smoke now? **If yes, answer these questions**  
 Total years smoking: .....

Types:	<input type="checkbox"/> Cigarette	<input type="checkbox"/> Pipe	<input type="checkbox"/> Cigar	<input type="checkbox"/> Chew
# per day				

Previous attempts to quit? If yes, included date(s) and describe attempt(s). .....

Did you smoke previously? **If yes, answer these questions**  
 Total years smoking: .....

Types:	<input type="checkbox"/> Cigarette	<input type="checkbox"/> Pipe	<input type="checkbox"/> Cigar	<input type="checkbox"/> Chew
# per day				

**Alcohol Use:** Describe your average weekly consumption.

Yes  No  Do you drink alcohol? **If yes, answer these questions**

Types:	<input type="checkbox"/> Wine (5 oz)	<input type="checkbox"/> Beer (12 oz)	<input type="checkbox"/> Mixed Drink (5 oz)	<input type="checkbox"/> Liquor (1.5 oz)
# per week				

Binge drinking (more than 4 drinks in a 24 hr period)?

Have you ever had a drinking problem? Explain: .....

**Drug Use:** Describe your past and current weekly drug use.

Yes  No  Have you ever used illicit drugs? **If yes, answer these questions**

<b>Amount:</b>	<b>0-1</b>	<b>2-4</b>	<b>5-9</b>	<b>10+ (specify #)</b>
Marijuana				
Cocaine				
Other				

Comments:  
 .....

**Other Concerns:**

Yes	No	Comments:
<input type="checkbox"/>	<input type="checkbox"/>	Previous military services
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Caffeine consumption
<input type="checkbox"/>	<input type="checkbox"/>	Occupational exposures
<input type="checkbox"/>	<input type="checkbox"/>	Hobby hazards
<input type="checkbox"/>	<input type="checkbox"/>	Sleep concern
<input type="checkbox"/>	<input type="checkbox"/>	Stress concern
<input type="checkbox"/>	<input type="checkbox"/>	Weight concern
<input type="checkbox"/>	<input type="checkbox"/>	Special diet
<input type="checkbox"/>	<input type="checkbox"/>	Back care
<input type="checkbox"/>	<input type="checkbox"/>	Exercise
<input type="checkbox"/>	<input type="checkbox"/>	Bike helmet (if you bicycle)
<input type="checkbox"/>	<input type="checkbox"/>	Seat belt use
<input type="checkbox"/>	<input type="checkbox"/>	Self examinations

Any other comments?  
 .....  
 .....  
 .....  
 .....  
 .....

**Immunizations** Please bring your immunization record on the day of your physical examination.

## Executive Health Psychology Questionnaire

Client Information				
<b>Last Name</b>	<b>First Name and Initial</b>	<b>Age</b>	<b>Date of Birth (MM/DD/YYYY)</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Marital Status</b>  <input type="checkbox"/> Married/Common-Law <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Never Married	<b>Do you have children?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many: _____ Gender: _____ Age: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female _____ <input type="checkbox"/> Male <input type="checkbox"/> Female _____ <input type="checkbox"/> Male <input type="checkbox"/> Female _____ <input type="checkbox"/> Male <input type="checkbox"/> Female _____	<b>Confidential Message can be left at:</b>  <b>Telephone # :</b>  1.) ..... 2.) ..... 3.) .....		

Over the past <u>month</u> , have you experienced any of the following? (Please check YES or NO)		
Lost interest or pleasure in any activities you normally enjoy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Feeling down, blue, depressed or low?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Periods of low energy, mood swings, irritability and/or loss of concentration?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Excessive worry about a number of issues (ex. health, finances, family, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Felt very nervous or anxious or suddenly experienced a lot of physical symptoms?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thoughts that you would like to moderate or eliminate alcohol consumption?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

How satisfied are you with the following areas in your life? Check after the number that corresponds to your satisfaction level										
	1=Not Satisfied					10=Very Satisfied				
Work Life	1	2	3	4	5	6	7	8	9	10
Family Life	1	2	3	4	5	6	7	8	9	10
Physical Health/Fitness	1	2	3	4	5	6	7	8	9	10
Intimate/Sexual Life	1	2	3	4	5	6	7	8	9	10
Level of Friendships/Social Support	1	2	3	4	5	6	7	8	9	10
Recreational/Social Life	1	2	3	4	5	6	7	8	9	10
Mood	1	2	3	4	5	6	7	8	9	10
Ability to Cope with Stress/Anxiety	1	2	3	4	5	6	7	8	9	10
Ability to Relax	1	2	3	4	5	6	7	8	9	10
Ability to Balance Home/Work	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10

Please describe any recent LIFE STRESSORS (e.g. health, relationships, financial, work)?
<p>.....</p> <p>.....</p> <p>.....</p>

How do you COPE WITH STRESS in your life (e.g., physical exercise, meditation, relaxation)? How helpful are these techniques at managing your current level of stress?
<p>.....</p> <p>.....</p> <p>.....</p>

Please indicate any specific concern or HEALTH & WELLNESS <u>GOAL</u> you would like to discuss with our psychology staff?	
<input type="checkbox"/> Stress management principles <input type="checkbox"/> Family relationships (spouse, children) <input type="checkbox"/> Mood/Anxiety <input type="checkbox"/> Healthier Lifestyle Choices (e.g., weight loss management)	<input type="checkbox"/> Work Life Balance <input type="checkbox"/> Preventative Health and Wellness <input type="checkbox"/> Alcohol consumption <input type="checkbox"/> Sleep Quality
Other: (please describe below)	
<p>.....</p>	

## Executive Health Nutrition Questionnaire

**Patient Information:**

Last Name	First Name and Initial	Age	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kgs.	Height <input type="checkbox"/> ins. <input type="checkbox"/> cms.
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**Have you made any changes to your diet or eating habits since your last Executive Health Physical:**  Yes  No

If yes, please provide details:

.....

.....

.....

**Have you made any changes to your supplementation routine since last year?**  Yes  No

Name	Dosage	Frequency
<input type="checkbox"/> new <input type="checkbox"/> discontinued <input type="checkbox"/> changed		
<input type="checkbox"/> new <input type="checkbox"/> discontinued <input type="checkbox"/> changed		
<input type="checkbox"/> new <input type="checkbox"/> discontinued <input type="checkbox"/> changed		
<input type="checkbox"/> new <input type="checkbox"/> discontinued <input type="checkbox"/> changed		

**Has your weight changed since last year's assessment?**  Yes  No

If yes:

- |   |   |
|---|---|
| <input type="checkbox"/> My weight has <b>increased</b> by approximately _____ lbs. | <input type="checkbox"/> My weight has <b>fluctuated</b> more than 5 lbs. over the past year. |
| <input type="checkbox"/> My weight has <b>decreased</b> by approximately _____ lbs. | <input type="checkbox"/> My weight has remained mostly <b>unchanged</b> over the past year.   |

**How do you feel about your weight?**

- |   |   |
|---|---|
| <input type="checkbox"/> I am comfortable with my present weight. | <input type="checkbox"/> I feel I have a significant amount of weight to lose (more than 10 lbs.) |
| <input type="checkbox"/> I would like to lose a few pounds.       | <input type="checkbox"/> I would like to gain weight.   |

**As a returning patient, you have the option of participating in a standard assessment (diet history and personalized suggestions), or you can use some of your consultation time to have a targeted session on a specific topic. If you would like to cover a specific topic during your nutrition consultation, please check one of the following:**

- |   |   |
|---|---|
| <input type="checkbox"/> Specific suggestions for food court, restaurant, or travel eating. | <input type="checkbox"/> Healthy and safe supplementation.      |
| <input type="checkbox"/> Sports/performance nutrition.                                      | <input type="checkbox"/> How to read and interpret food labels. |
| <input type="checkbox"/> Organic foods and environmental issues related to food choices.    |   |

**Do you have any questions for the Dietitian?**  Yes  No

Please list:

.....

.....

.....

