Cleveland Clinic

Executive Health

Medical History

Date: ____/____/____

Please fax back to 216.445.2144 or hand carry to your appointment. Do not mail.

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

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

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

Cell Phone (____) _____ Email Address _____

Employer _____ Occupation _____

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

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

Current symptoms or problems you would like evaluated?

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

Known medical conditons you have or are being treated for:

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

Previous hospitalizations/operations:

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

Prior serious illness, injuries and broken bones:

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

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

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

List all non prescription medications, vitamins, and supplements you are taking:

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

Do you take aspirin or over-the-counter pain medication? ☐ Yes ☐ No

If so, what drug and frequency _____

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)

Vaccine	Date	Vaccine	Date
Tetanus/Diphtheria	_____	Pneumococcal	_____
Hepatitis A	_____	Hepatitis B	_____
Influenza	_____	Herpes Zoster (Shingles)	_____
Other			

Family History: List parents, all natural brothers and 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	_____	_____
Spouse	☐ Yes ☐ No	_____	_____

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

☐ Stroke
☐ Heart Attack/Angioplasty/Heart Surgery
☐ Blood Pressure
☐ High Cholesterol/Triglycerides
☐ Diabetes
☐ Brain Aneurysm
☐ Aortic Aneurysm
☐ Tuberculosis
☐ Asthma
☐ Emphysema
☐ Glaucoma
☐ Arthritis
☐ Liver Disease
☐ Colon Cancer
☐ Colon Polyps
☐ Breast Cancer
☐ Other Cancer
type _____
☐ Thyroid Disease
☐ Kidney Disease
☐ Osteoporosis
☐ Mental Health Disease
☐ Alcoholism
☐ Migraine Headaches
☐ Epilepsy (Seizures)
☐ Other Problems:
_____

General

☐ Yes ☐ No Have you had skin disease or skin cancer?
☐ Yes ☐ No Do you have any lumps in your skin of concern to you?
☐ Yes ☐ No Are any moles getting larger or changing color?
☐ Yes ☐ No Do you have any problem with skin rashes?
☐ 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 or your family noticed your hearing has changed?
☐ Yes ☐ No Do you have ringing in the ears?
☐ Yes ☐ No Do you wear a hearing aid?
☐ Yes ☐ No Do you lose your balance or fall?
☐ Yes ☐ No Have you had or been treated for vertigo?
☐ Yes ☐ No Are you often hoarse?
☐ Yes ☐ No Do you have sinus trouble?
If so, at any particular time of the year _____

Cardiopulmonary

☐ Yes ☐ No Do you have hay fever or asthma?
☐ 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 pain in the legs 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 blood clot or thrombophlebitis?
☐ Yes ☐ No Have you had a stress test, echocardiogram or heart catheterization?
(If done other than at Cleveland Clinic, please bring report with you)
☐ Yes ☐ No Have you had ultrasound of the abdominal aorta and/or of the carotid arteries?

Gastrointestinal

☐ Yes ☐ No Have you had trouble swallowing?
☐ Yes ☐ No Do you have heartburn?
☐ 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 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 a polyp or cancer in your colon or rectum?

Gastrointestinal cont.

☐ Yes ☐ No Have you had rectal bleeding, blood with your stool, or blood on toilet paper?
☐ Yes ☐ No Do you have hemorrhoids?
☐ 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 _____
☐ Yes ☐ No Date, place and result of your most recent proctosigmoidoscopy or colonoscopy
_____

Genitourinary

☐ 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 noticed blood in your urine?
☐ Yes ☐ No Have you had kidney stones? If yes, when _____
Type of stones if known _____
☐ Yes ☐ No Do you have decreased sexual drive?
☐ Yes ☐ No Are there sexual issues you wish to discuss?

Musculoskeletal

☐ Yes ☐ No Have you had back pain?
If so does it go down into the buttock, thigh, calf or foot? ☐ Yes ☐ No
☐ Yes ☐ No Have you had joint pain? If so, which joint? _____
☐ Yes ☐ No Do you have muscle pain? If so, where? _____
☐ Yes ☐ No Do you have excessive muscle tension? If yes, when? _____
☐ Yes ☐ No Do you have neck pain? When _____
☐ Yes ☐ No Have you had fractures as an adult?

Miscellaneous

☐ Yes ☐ No Have you had seizures or convulsions as an adult? If so, when? _____
☐ 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? _____
☐ Yes ☐ No Have you had significant stress recently?
☐ Yes ☐ No Have you had significant anger recently?
☐ Yes ☐ No Have you had significant sadness or depression recently?
☐ 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
☐ Yes ☐ No Do you take medication or supplements for sleep?
If yes, what and how often _____
☐ Yes ☐ No Do you snore heavily?
☐ Yes ☐ No Have you been observed to stop breathing when sleeping?
☐ Yes ☐ No Are you frequently tired or fatigued?
☐ Yes ☐ No Are you frequently 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 significant 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 smoke now? If so:
_____ packs of cigarettes/day or week
_____ cigars/day or week _____ (pipe) pouches/day or week
_____ total years smoking
☐ Yes ☐ No Did you smoke previously? If so:
When did you quit? _____ _____ packs/day _____ Total years smoking
☐ Yes ☐ No Do you were a seatbelt whenever in the car?
☐ Yes ☐ No Do you consume alcohol? If so:
Liquor _____ drinks/day or week (1 drink = 1.5 oz liquor)
Wine _____ glasses/day or week (1 glass wine = 5 oz wine)
Beer _____ bottles or glasses/day or week (1 bottle or glass beer = 12 oz)
☐ Yes ☐ No Do you drink coffee? If so:
caffeinated _____ cups/day
decaffeinated _____ cups/day
☐ Yes ☐ No Do you drink caffeinated soda? If so:
_____ ounces/day ☐ Diet or ☐ Regular

For Females Only

☐ Yes ☐ No Do you have any vaginal problems or symptoms?
☐ Yes ☐ No Do you have any breast tenderness or nipple discharge?
☐ 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 Is premenstrual tension a problem for you?
☐ Yes ☐ No If postmenopausal, are you having vaginal spotting or bleeding?
☐ Yes ☐ No Are you having problems with hot flashes?
☐ Yes ☐ No Do you have concern about physical or emotional abuse?

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 _____

For Males Only

☐ Yes ☐ No Have you had problems emptying your bladder completely?
☐ Yes ☐ No Do you have trouble getting or maintaining an erection?
☐ Yes ☐ No Has your PSA (prostate specific antigen) blood test been elevated?

Nutrition

Have you ever been diagnosed with:

☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Reflux (heartburn)
☐ Yes ☐ No Lactose intolerance
☐ Yes ☐ No High blood sugars
☐ Yes ☐ No Diabetes
☐ Yes ☐ No High cholesterol
☐ Yes ☐ No Low good cholesterol (HDL)
☐ Yes ☐ No High triglycerides
☐ Yes ☐ No Other nutrition-related condition:
☐ 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 ☐ South Beach ☐ Weight Watchers ☐ Jenny Craig ☐ 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 dietician 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, cafeterias, catered or social functions: ☐ 0-3 times per week ☐ 4-6 times per week ☐ 7+ times per week

Do you add salt to your foods? ☐ Never-Rarely ☐ Occasionally ☐ Often

Foods you consume on a regular basis:
☐ deli and cured meats ☐ cheese ☐ non homemade soups ☐ frozen foods
☐ chips ☐ boxed rice ☐ noodle mixes

Do you typically skip meals? ☐ Yes ☐ No If yes, which meal? _____

Do you read food labels? ☐ Never-Rarely ☐ Occasionally ☐ Often

Do you choose reduced fat or fat-free products when available? ☐ Never-Rarely ☐ Occasionally ☐ Often

Do you eat doughnuts, croissants, muffins, or sweet rolls? ☐ Never-Rarely ☐ Occasionally ☐ Often

Please choose those you consume on a regular basis:
☐ fried foods ☐ regular salad dressing ☐ regular cheese
☐ butter ☐ oil ☐ peanut butter
☐ margarine ☐ gravy ☐ cream sauces

Nutrition cont.

How many servings do you have from the dairy group/day? _____
(A serving is 8 oz milk/yogurt or soy milk, 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, 2 tablespoons raisins, 1 cup fresh fruit, ½ cup canned fruit)

Do you eat whole grains daily? (A serving is 1 slice whole grain bread, ½ cup brown or wild rice, ½ cup whole grain pasta, ¾ cup cereal with at least 5 grams of fiber, popcorn, etc)

☐ Yes ☐ No If yes, number of servings per day _____

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

☐ Yes ☐ No If yes, number of ounces per day _____

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

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

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 steps can you walk up before becoming winded? _____

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

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

If so, what? _____

Work

☐ Yes ☐ No Number of work hrs/week _____

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

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 you wish to be scheduled at Cleveland Clinic on the day of your physical. Specify department and physician.

_____

_____

_____