

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. _____
2. _____
3. _____
4. _____

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

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

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

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

Date of your last colonoscopy: _____ 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Children	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack/Angioplasty/Heart | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Health Disease |
| <input type="checkbox"/> High Cholesterol/Triglycerides | <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Colon Polyps |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Brain Aneurysm | <input type="checkbox"/> Epilepsy (Seizures) | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Blindness | <input type="checkbox"/> Other Cancer _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> 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 apnea?
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.
