Executive Health Program
10 Plum Street, 8th Floor
New Brunswick, NJ 08901

Date: _____

Name: _____

Address: _____

Telephone Numbers: Home _____
Work _____
Fax _____
Cell _____

E-mail address _____

Date of Birth _____ Current Age _____

Social Security Number _____

Gender: ○ Male ○ Female

Marital Status: ○ Married ○ Never married ○ Separated ○ Divorced ○ Widowed

Occupation (current or former if retired): _____

Retired: ○Yes ○ No Year of retirement _____

Contact Person (for emergencies):

Name: _____ Relationship: _____

Address: _____ Telephone Number: Home _____

_____ Work _____

Contact Person (for scheduling):

Name: _____ Relationship: _____

Address: _____ Telephone Number: Work _____

_____ Fax _____

Personal Physician:

Name: _____ Specialty: _____

Address: _____ Telephone Number: Work _____

_____ Fax _____

Do you want us to send the results from your visit to your physician? ○ Yes ○ No

Pharmacy Information:

Name: _____ Telephone Number: _____

Address: _____

_____

How did you hear about this program? _____

Please describe any issue(s) you would like to discuss at your visit:

Please describe any specific testing or evaluation that you are interested in discussing:

Please describe any specific nutritional or exercise issues that you would like discussed:

Medical Information

List any medical or psychological conditions for which you have been treated.

○ None

List any surgeries or operations you have undergone and the year performed.

○ None

Have you ever had any difficulties with general anesthesia? ○ Yes ○ No

Have you ever received a blood transfusion? ○ Yes ○ No

List any serious injuries you have had ○ None

List any hospitalizations for any condition not previously described. ○ None

List any **prescription** medications. ○ None

Medication name	Dose strength	Frequency	Who prescribed?
Example: simvastatin	*40 mg*	*2 times per day*	*Dr. Fred Smith*

List any non-prescription/over-the-counter medications you are taking. ○ None

List any vitamins, herbal substances, or supplements you are taking. ○ None

Describe any other allergies ○ None

Health Behaviors

Do you, or have you ever, smoked cigarettes, cigars or a pipe? ○ YES ○ NO

(If yes check the box(es) that which applies)

- ☐ Amount per day: _____
- ☐ Number of years: _____
- ☐ Year quit: _____

Do you use any other form of tobacco? _____ ○ YES ○ NO

Do you drink any alcohol? ○ YES ○ NO

Average number of drinks per week _____

Have you ever cut down on your drinking? ○ YES ○ NO

Has anyone ever annoyed you or bothered you about your drinking? ○ YES ○ NO

Have you ever felt bad or guilty about your drinking? ○ YES ○ NO

Have you ever had a drink the first thing in the morning? ○ YES ○ NO

Have you ever used recreational drugs? ○ YES ○ NO

Have you ever injected drugs? ○ YES ○ NO

Do you eat a low-fat diet? ○ YES ○ NO

Do you eat 5 servings of fruits and vegetables daily? ○ YES ○ NO

Do you drink caffeinated beverages? ○ YES ○ NO

Coffee (# of cups) _____ tea (# cups) _____

Soda (glasses) _____

Do you exercise regularly? ○ YES ○ NO

Describe your exercise/frequency: _____

Do you regularly wear seatbelts? ○ YES ○ NO

Do you regularly use sunscreen? ○ YES ○ NO

Preventive Care

Have you ever had any of the following preventive screening tests?

-Colonoscopy	○ YES	○ NO	If yes, date of last test _____
-Mammogram	○ YES	○ NO	If yes, date of last test _____
-PAP smear	○ YES	○ NO	If yes, date of last test _____
-Bone Density Test (DEXA)	○ YES	○ NO	If yes, date of last test _____
-PSA (prostate blood test)	○ YES	○ NO	If yes, date of last test _____
-Cholesterol test	○ YES	○ NO	If yes, date of last test _____
-Stress test	○ YES	○ NO	If yes, date of last test _____
-Dental examination	○ YES	○ NO	If yes, date of last test _____
-Eye examination	○ YES	○ NO	If yes, date of last test _____
-Hearing examination	○ YES	○ NO	If yes, date of last test _____

IMMUNIZATIONS	Ever received		Date of Last Booster
Tetanus (or dT, dTP or Adacel)	○ YES	○ NO	_____
Hepatitis B Vaccine	○ YES	○ NO	_____
Influenza Vaccine	○ YES	○ NO	_____
Pneumococcal pneumonia vaccine (Pneumovax)	○ YES	○ NO	_____
Measles, Mumps, Rubella (MMR)	○ YES	○ NO	_____
Zoster (Shingles)	○ YES	○ NO	_____
BCG (this is tuberculosis VACCINE not a TB skin test)	○ YES	○ NO	_____
Other: what type_____			_____

Family History

		AGE		Medical Problems	Age & cause of death
MOTHER					
FATHER					
		Age	Sex		
SIBLINGS Brothers and/or Sisters					
CHILDREN					

Has any member of your family members had any of the following?

	Disease Present	If yes, describe
Heart disease	○ Yes ○ No	_____
High blood pressure	○ Yes ○ No	_____
Diabetes	○ Yes ○ No	_____
High cholesterol	○ Yes ○ No	_____
Alcohol or drug problems	○ Yes ○ No	_____
Depression or suicide	○ Yes ○ No	_____
Cancer	○ Yes ○ No	_____
Any other disease which runs in your family	○ Yes ○ No	_____

Have you recently had:

Unexplained fevers or chills?	○ YES	○ NO
Unexplained sweating?	○ YES	○ NO
Unexplained swollen lymph nodes ("glands")?	○ YES	○ NO
Poor appetite?	○ YES	○ NO
Unusual amount of fatigue?	○ YES	○ NO
General weakness/malaise?	○ YES	○ NO
Sudden loss of vision?	○ YES	○ NO
Double vision?	○ YES	○ NO
Pain in your eyes?	○ YES	○ NO
Discharge from one or both eyes?	○ YES	○ NO
Unusual sensitivity to light?	○ YES	○ NO
Blurry vision?	○ YES	○ NO
Halos around objects in your vision?	○ YES	○ NO
Ringing in the ears?	○ YES	○ NO
Difficulty hearing?	○ YES	○ NO
Ear pain?	○ YES	○ NO
Ear discharge?	○ YES	○ NO
Persistent hoarseness?	○ YES	○ NO
Sore throat?	○ YES	○ NO
Sores or lumps in your mouth that won't heal?	○ YES	○ NO
Nasal congestion?	○ YES	○ NO
Nose bleeds?	○ YES	○ NO
Are you frequently exposed to loud noise (music, airplanes, etc.)?	○ YES	○ NO

Have you ever had an abnormal EKG? ○ YES ○ NO

Have you ever had high cholesterol? ○ YES ○ NO

Have you ever had high blood pressure? ○ YES ○ NO

Have you ever had high blood sugar of diabetes? ○ YES ○ NO

Have you lost more than 10 pounds unintentionally over the past year? ○ YES ○ NO

Have you gained more than 10 pounds over the past year? ○ YES ○ NO

Have you ever had an abnormal chest x-ray? ○ YES ○ NO

Do you have long-standing or frequent coughing? ○ YES ○ NO

Have you recently had difficulty breathing? ○ YES ○ NO

Have you recently coughed up blood? ○ YES ○ NO

Have you recently had wheezing? ○ YES ○ NO

Have you recently coughed up sputum or phlegm? ○ YES ○ NO

Do you have trouble sleeping? ○ YES ○ NO

Do you have excessive snoring? ○ YES ○ NO

Do you feel exhausted when you wake up in the morning? ○ YES ○ NO

Do you feel excessively sleepy or fall asleep during the day? ○ YES ○ NO

With exertion (walking, climbing stairs, etc) do you have:

Chest discomfort (pain or heaviness)? ○ YES ○ NO

Shortness of breath? ○ YES ○ NO

Arm discomfort? ○ YES ○ NO

Do you have difficulty breathing at night? ○ YES ○ NO

Do you get short of breath if you lie flat in bed? ○ YES ○ NO

Do you have a sense of fluttering in the chest? ○ YES ○ NO

Racing or skipping of heartbeat? ○ YES ○ NO

Do you have frequent swelling of your legs, ankles or feet? ○ YES ○ NO

Do you have leg pains on walking a short distance? ○ YES ○ NO

Have you ever been told that you had a heart murmur? ○ YES ○ NO

Do you have difficulty swallowing? ○ YES ○ NO

Does food stick in your chest when you swallow? ○ YES ○ NO

Do you have frequent heartburn (burning sensation in the chest)? ○ YES ○ NO

Have you ever had stomach ulcers? ○ YES ○ NO

Do you vomit frequently? ○ YES ○ NO

Have you ever vomited blood? ○ YES ○ NO

Have you ever had jaundice (yellowing of skin),
liver disease, or gall bladder disease? ○ YES ○ NO

Have you ever had an upper endoscopy? ○ YES ○ NO
(a tube passed through the mouth to look around the stomach)

Have you ever had a growth or polyp in the intestine? ○ YES ○ NO

Have you ever had X-rays or ultrasound tests of the stomach, colon, or gallbladder? ○ YES ○ NO

Have you passed blood with a bowel movement within the past year? ○ YES ○ NO

Have you had a black, tarry stool within the past year? ○ YES ○ NO

Do you sometimes lose control of bowel movements? ○ YES ○ NO

Do you have severe or recurrent abdominal pain? ○ YES ○ NO

Do you have nausea? ○ YES ○ NO

Do you often have constipation? ○ YES ○ NO

Do you frequently take a laxative? ○ YES ○ NO

Do you often have diarrhea? ○ YES ○ NO

Has there been any change in your bowel movements (e.g. in color or shape)? ○ YES ○ NO

Do you have pain with urination? ○ YES ○ NO

Do you get up at night to urinate? ○ YES ○ NO
If yes, how many times? _____

Do you have any sores growths or warts on the rectal area? ○ YES ○ NO

Do you sometimes lose control of urine? ○ YES ○ NO

Have you recently passed blood in your urine? ○ YES ○ NO

Do you urinate more frequently than normal? ○ YES ○ NO

Have you ever had a kidney or bladder infection? ○ YES ○ NO

Have you ever had kidney stones? ○ YES ○ NO

Have you ever had any other kidney problem? ○ YES ○ NO
If yes, please explain _____

Are you sexually active? ○ YES ○ NO

Do you consider yourself? (check the box(es) which ever applies)
□ heterosexual □ homosexual □ bisexual □ transgender

Have you ever had any sexually transmitted diseases
such as herpes, gonorrhea, warts, or syphilis? ○ YES ○ NO

Should we discuss issues relating to sexually transmitted diseases? ○ YES ○ NO

Have you had lightheadedness? ○ YES ○ NO

Have you recently had seizures? ○ YES ○ NO

Have you ever had migraines? ○ YES ○ NO

Have you had frequent or severe headaches? ○ YES ○ NO

Have you had poor balance? ○ YES ○ NO

Have you had a disturbance in coordination? ○ YES ○ NO

Do you have difficulty walking? ○ YES ○ NO

Have you had a sensation of the room spinning? ○ YES ○ NO

Have you recently passed out or lost consciousness? ○ YES ○ NO

Have you recently had the inability to speak? ○ YES ○ NO

Do you have any numbness in any part of your body? ○ YES ○ NO

Do you have any tingling in any part of your body? ○ YES ○ NO

Do you have tremors (shaking) of any part of your body? ○ YES ○ NO

Do you have weakness of your arms, legs or face? ○ YES ○ NO

Have you noticed any recent problems with your memory? ○ YES ○ NO

Have you had muscle cramps or pain? ○ YES ○ NO

Do you have any pain, swelling, stiffness in your joints? ○ YES ○ NO

Have you ever been diagnosed with arthritis? ○ YES ○ NO

Have you ever been diagnosed with gout? ○ YES ○ NO

Do you have back pain? ○ YES ○ NO

Do you have neck pain? ○ YES ○ NO

Do you have any skin rash or other skin change? ○ YES ○ NO

Do you have a mole, which is new or changing? ○ YES ○ NO

Do you have any unusual change in your hair? ○ YES ○ NO

Do you have any changes in your nails? ○ YES ○ NO

Have you ever taken steroids, thyroid or other hormones? ○ YES ○ NO

Have you ever had anemia? ○ YES ○ NO

Have you ever had clots in the veins or lungs? ○ YES ○ NO

Have you ever had any problems with excessive bleeding? ○ YES ○ NO

Do you live alone? ○ YES ○ NO

Are there pets in your house? If so, what kinds? _____ ○ YES ○ NO

Do you think you may have been exposed to:

AIDS/HIV? ○ YES ○ NO

Lyme Disease? ○ YES ○ NO

Hepatitis? ○ YES ○ NO

Have you ever had tuberculosis? ○ YES ○ NO

Have you ever had worrisome exposures on your job or at home? ○ YES ○ NO

(e.g., asbestos, radiation, chemicals, etc.)

Have you ever seen a psychotherapist or been treated for depression or a nervous disorder?	○ YES	○ NO
Have you recently considered harming yourself or had suicidal thoughts?	○ YES	○ NO
Have you ever received counseling for or been involved in an alcohol or drug detox/rehabilitation program?	○ YES	○ NO
Has a family member or partner every hit you, physically hurt you or threatened you?	○ YES	○ NO
Has anyone ever forced you to have sexual activities with him or her?	○ YES	○ NO
Are you interested in living wills?	○ YES	○ NO

MEN ONLY

Do you have any difficulty starting urination?	○ YES	○ NO
Do you have dribbling after urination?	○ YES	○ NO
Do you have a lump or mass in the testicles or scrotum?	○ YES	○ NO
Do you have difficulty achieving or maintaining an erection?	○ YES	○ NO
Do you have any discharge from the penis?	○ YES	○ NO
Do you have any swelling testicles or scrotum?	○ YES	○ NO
Do you have any sexual problems you wish to discuss?	○ YES	○ NO

WOMEN ONLY

Do you have vaginal bleeding after intercourse?	○ YES	○ NO
Do you have any vaginal itching?	○ YES	○ NO
If after menopause, do you have any vaginal dryness or discomfort?	○ YES	○ NO
Do you have any vaginal discharge?	○ YES	○ NO
Are your periods very painful?	○ YES	○ NO
Are your periods very irregular?	○ YES	○ NO
Do you have any vaginal bleeding between periods?	○ YES	○ NO
Do you have any sores, growths or warts on the genitals?	○ YES	○ NO
If after menopause, have you had any vaginal bleeding or spotting at all?	○ YES	○ NO
If after menopause, do you have any hot flashes?	○ YES	○ NO
Do you have any sexual problems you wish to discuss?	○ YES	○ NO

WOULD YOU LIKE ANY ADDITIONAL INFORMATION (please check the box(es))

☐ **Cholesterol treatment**

☐ **Immunizations and vaccines**

☐ **Exercise information (please list)** _____

☐ **Nutritional information (please list)** _____

☐ **Vitamins and supplements (please list)** _____

Clear Save for Later Email EHP