The EXECUTIVE EVALUATION CENTER
A division of SMG Innovations, Inc.

Comprehensive Physical Examination

Returning Patient Medical Questionnaire

Patient Name: _____

Exam Date: _____

Welcome back to the Executive Evaluation Center. As you know, in an effort to provide you with the greatest opportunity for a long and productive life, you will receive what we believe to be

the most comprehensive health evaluation available in this country. The following questionnaire has been streamlined for your convenience and will assist your physician in formulating a comprehensive medical assessment. It is essential that you provide interval changes in your medical and family situation and details of any current health concerns to allow your physician to be more effective in assessing your present and future health concerns. Of course, if there have been no changes since your last visit, you may simply write "no change." Your responses will be reviewed with you by your physician during your comprehensive evaluation.

A) PRESENT HEALTH STATUS

1. What is your present age? _____
2. What is your gender: ❑ Male ❑ Female
3. How do you assess your present overall health status? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
4. What has been the pattern of your health picture over the past few years?
   ❑ Stable ❑ Improving ❑ Declining
5. How content are you with your present general health?
   ❑ Very content ❑ Somewhat content ❑ Disappointed in present health
6. Do you have a personal physician? ❑ Yes ❑ No
   If yes: Physician Name_____ Physician Phone#_____
   Physician Location_____
7. Would you like a copy of your report to be sent to your physician ❑ Yes ❑ No
8. Are you interested in learning more about the Dedicated Care Center, our membership-based "concierge" medical practice? ❑ Yes ❑ No

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B) Past Medical History

1. Have you had any significant medical illnesses since your last evaluation?: ❑ Yes ❑ No

If yes: Heart Disease	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Lung Disease	❑ Yes	❑ No	Lung Cancer	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No	Unusual Infections	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Emphysema/COPD	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No

Other new Illnesses/Concerns ❑ Yes ❑ No *(If yes, please explain below)*

_____

_____

_____

2. Have you been hospitalized for anything other than surgery since your last evaluation? ❑ Yes ❑ No

   If so, for what, and when? _____

   _____

3. What surgical procedures have you undergone since your last evaluation, who was your surgeon and when was the surgery performed?

   _____

   _____

   _____

4. Have you had an injury since your last evaluation that left you with any compromise of function? ❑ Yes ❑ No

   If yes, please explain: _____

5. Have you had any specialized diagnostic procedures since your last evaluation? (i.e. heart catheterization, CAT or MRI scans, treadmill studies, etc.) ❑ Yes ❑ No

   If yes, please explain below (with date(s)):_____

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6. Please list all medications you are taking (including prescription, herbal and over-the-counter medications)? Please make sure to list EVERY medication, including dosages, and directions.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you taking Aspirin 81 mg daily? ❑ Yes ❑ No

Are you taking Vitamin E daily? ❑ Yes ❑ No

Are you taking Folbee or a folic acid/Vitamin B supplement? ❑ Yes ❑ No

Are you taking any Calcium supplement? ❑ Yes ❑ No

Are you taking any Vitamin D supplement? ❑ Yes ❑ No

7. Please check the vaccinations you have had since your last evaluation and list when you received them:

❑ Pneumovax ❑ Hepatitis A / B series ❑ Tetanus (Td / TdAP) ❑ Shingles (Zostavax) ❑ Influenza

Date: _____ _____ _____ _____ _____

8. Have you had any travel-related vaccinations since your last evaluation (Typhoid, Yellow Fever, Hepatitis A, etc.)?

If so, please list these and the date(s) they were received:

_____

9. Do you have any drug or food allergies? ❑ Yes ❑ No

If yes, please list these below and the reaction you experienced:

_____

10. Are you allergic to:

Iodine	❑ Yes	❑ No
Seafood	❑ Yes	❑ No
Intravenous Contrast Dye	❑ Yes	❑ No

If yes, what reaction do you have? _____

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C) FAMILY HISTORY

Father	Mother	Siblings
Is your father living? ❑ Yes ❑ No	Is your mother living? ❑ Yes ❑ No	<u>Living siblings:</u> 1. ❑ Male ❑ Female Age:_____ Health concerns:_____ 2. ❑ Male ❑ Female Age:_____ Health concerns:_____ 3. ❑ Male ❑ Female Age:_____ Health concerns:_____ 4. ❑ Male ❑ Female Age:_____ Health concerns:_____ 5. ❑ Male ❑ Female Age:_____ Health concerns:_____
How old is he, if still living? _____ Or: Age at death:_____ Cause of death: _____	How old is she, if still living? _____ Or: Age at death:_____ Cause of death: _____	<u>Deceased siblings:</u> 1. ❑ Male ❑ Female Age at death:_____ Cause of death:_____ 2. ❑ Male ❑ Female Age at death:_____ Cause of death:_____ 3. ❑ Male ❑ Female Age at death:_____ Cause of death:_____ 4. ❑ Male ❑ Female Age at death:_____ Cause of death:_____ 5. ❑ Male ❑ Female Age at death:_____ Cause of death:_____
Does / did your father have any of the following medical problems? ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses *Please provide details:*	Does / did your mother have any of the following medical problems? ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses: *Please provide details:*	*Additional:*

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D) SOCIAL HISTORY

Tobacco Use	Alcohol Use	Caffeine / other Drug Use
Do you currently use tobacco products? ❑ Yes ❑ No How many cigarettes do you smoke daily? _____/day For how many years have you been smoking _____ years	Do you now drink or have your previously drunk alcohol regularly? ❑ Yes ❑ No	Do you ingest caffeine regularly? ❑ Yes ❑No
	How many drinks do you drink daily? _____/day	How many caffeinated drinks do you drink daily? _____/day
Have you ever used tobacco products? ❑ Yes ❑ No If so, how many cigarettes did you smoke daily? _____/day For how many years did you smoke _____ years	Do you think you have / had a problem with drinking? ❑ Yes ❑ No	Do you think you are addicted to caffeine? ❑ Yes ❑ No
Do you / Have you: ❑ ever use other forms of tobacco products? ❑ want to quit? ❑ Think you can quit? ❑ ever been able to quit?	Have you ever: ❑ felt the need to cut down on our drinking? ❑ felt annoyed by others criticizing our drinking ❑ ever felt guilty about drinking? ❑ ever felt the need for a drink first thing in the morning?	Do you / have you ever: ❑ had caffeine withdrawal symptoms such as headache ❑ used any "recreational" / street drugs? If so, please list them:

Family / Work / Fitness

1. What is your marital status?

   ❑ married ❑ remarried ❑ divorced ❑ widowed ❑ engaged ❑ single

2. Are you satisfied in your present marital state? ❑ Yes ❑ No

3. Are there topics that you would like to discuss in complete confidence regarding your social or sexual life? (HIV testing, etc.) ❑ Yes ❑ No

4. Do you have children? ❑ Yes ❑ No

   If "yes", please list their ages, genders and any new medical problems they have has since your last evaluation:

   _____

   _____

   _____

5. Are you employed? ❑ Yes ❑ No

   If yes, what is your position and profession? _____

6. Are you satisfied with your present lifestyle and daily responsibilities? ❑ Yes ❑ No

7. Are your stress levels acceptable to you? ❑ Yes ❑ No

8. Do you have plans for five years into the future that seem fulfilling? ❑ Yes ❑ No

9. Are you exposed to toxins, irritants, allergens, etc. in your employment or home? ❑ Yes ❑ No

   If "yes", please indicate how and when _____

10. How many hours per week do you devote to sedentary activities? _____

11. How much vacation do you take in an average year? _____

12. When was your last vacation of one week or more? _____

13. What is the approximate length of your longest annual vacation? _____

14. What is your assessment of your present state of physical fitness?

    ❑ Poor ❑ Below Average ❑ Average ❑ Above Average ❑ Excellent

15. Do you have a regular exercise program? ❑ Yes ❑ No

    If so, what is it? _____

16. Do you participate in strenuous sports activities? (Tennis, swimming, running etc.) ❑ Yes ❑ No

    If "yes", what activities: _____

17. Are you aware of the association of improved longevity with regular exercise? ❑ Yes ❑ No

E) REVIEW OF SYSTEMS

(If you answer "Yes" to any of these questions, please provide further details in the space below each question)

General:

1. How would you assess your overall health picture?

   _____

   _____

2. What are the weakest points of your overall health? (Smoking, alcohol, stress, sedentary lifestyle, family history, etc.)

   _____

If you have had any new problems since your last evaluation, please answer the following questions. If not, please skip to page 12.

Head:

1. Do you currently suffer from headaches? ❑ Yes ❑ No

   If so, have they been "labeled"(i.e. migraines, tension, cluster, etc.)

   _____

2. Is your hearing compromised? ❑ Yes ❑ No

   If "yes", have you experienced acoustic trauma, ear disease, or has there been any new family history of a hearing deficit?

   _____

3. Have there been any changes in your vision? ❑ Yes ❑ No

4. Have you noted any transient changes in your visual fields? (i.e. "blind spots") ❑ Yes ❑ No

   If so, in which eye, for how long, and when?_____

5. Have you had an eye examination within the past two years? ❑ Yes ❑ No

   If so, please provide the following information:
   Name of eye doctor: _____ Date of eye examination (if known):____/____/_____

6. Have you experienced allergic symptoms? (sniffling, nasal congestion, etc.) ❑ Yes ❑ No

7. Have you experienced hoarseness, or other recurrent abnormalities of voice? ❑ Yes ❑ No

Neck:

1. Have you experienced neck pain or stiffness? ❑ Yes ❑ No

   If so, are there provoking factors? _____

2. Have you experienced swollen glands in the neck? ❑ Yes ❑ No

   If so, are they associated with a sore throat, or other signs of infection? _____

3. Have you experienced thyroid enlargement (goiter), or neck tenderness?

Lymphatic System:

1. Have you experienced persistent swollen glands of the neck, underarms, groin or thighs? ❑ Yes ❑ No

   If yes, please describe: _____

Chest:

1. Have you experienced chest pain, shortness of breath, asthma, emphysema, COPD, cough, chest congestion wheezing, or diminished exercise tolerance? ❑ Yes ❑ No

   If yes, please describe:_____

Heart:

1. Have you experienced exertional chest pain, angina, heart attack, congestive heart failure, tightness, burning, fullness, or any other unusual sensations noted with activity? ❑ Yes ❑ No

   If yes, please describe:_____

   _____

2. Have you experienced skipped heartbeats, or inappropriately rapid or irregular heart rhythm? ❑ Yes ❑ No

   If yes, please describe:_____

Abdomen:

1. Have you experienced chronic or recurrent abdominal pain, indigestion, nausea, vomiting, diarrhea, constipation or previous endoscopy procedures? ❑ Yes ❑ No

2. Have you experienced belching of stomach acid, severe or recurrent "heartburn"? ❑ Yes ❑ No

   If so, please list provoking factors: _____

3. Have you noted jaundiced skin or Coca-Cola colored urine? ❑ Yes ❑ No

4. Have you noted any change in bowel habits, such as dark stools, diminished caliber of the stool, straining at defecation, or a persistent feeling of the need to evacuate the bowel unrelieved by passage of stool? ❑ Yes ❑ No

   If yes, please describe:_____

5. Have you or anyone in your immediate family (parents, grandparents, children, siblings) been diagnosed with any of the following conditions?

Colon Cancer	❑ Yes ❑ No
Colon Polyps (malignant or benign)	❑ Yes ❑ No
Familial Adenomatous Polyposis	❑ Yes ❑ No
Other Major abdominal disease	❑ Yes ❑ No

   If yes, please specify_____

   _____

6. Have you had a colonoscopy, flexible sigmoidoscopy or upper endoscopy (EGD)? ❑ Yes ❑ No

   If yes, when did you have it and what did it show? _____

   _____

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Genitourinary Tract (Female):

1. Do you have a history of recurrent bladder infections? ❑ Yes ❑ No

2. Do you have a history of recurrent vaginal infections? ❑ Yes ❑ No
   If so, are they usually precipitation factors, such as antibiotic therapy? ❑ Yes ❑ No

3. How many pregnancies have you had? _____
   How many full-term deliveries? _____
   How many miscarriages? _____
   Did you breast-feed your children? ❑ Yes ❑ No

4. Were you ever told of diabetic tendencies during pregnancy? ❑ Yes ❑ No

5. Do you have any questions about your sex drive or sexual performance? ❑ Yes ❑ No

6. When was your last Pap smear? _____
   Have you ever had an abnormal Pap smear? ❑ Yes ❑ No
   If so what actions followed that discovery? _____

7. When was your last mammogram? _____
   Have you ever had an abnormal mammogram? ❑ Yes ❑ No
   If so when was this discovery? _____
   If so what actions followed this discovery? _____

8. At approximately what age did your mother enter menopause?_____
   Have you experienced hot flashes, mood swings, personality changes or other manifestations or menopausal syndrome? ❑ Yes ❑ No

   If so, are they resolved, diminishing or increasing? _____
   Are you now, or in the future, planning to use hormonal replacement therapy to diminish menopausal changes or complaint? ❑ Yes ❑ No

9. Have you undergone bone density studies in the past? ❑ Yes ❑ No
   If so, what were the results? _____

10. Do you take calcium supplements? ❑ Yes ❑ No
    If so, in what form? _____

Genitourinary Tract (Male):

1. Have you had a bladder or prostate infection since your last evaluation? ❑ Yes ❑ No

2. Have you been told of prostate enlargement? ❑ Yes ❑ No

3. Have you experienced a diminished size and force of the urinary stream? ❑ Yes ❑ No

4. Is your sexual performance adequate? ❑ Yes ❑ No

5. Is there is a problem that would justify further investigation? ❑ Yes ❑ No

Extremities:

1. Have you experienced chronic or recurrent joint pain, swelling, stiffness or redness? ❑ Yes ❑ No

2. Have you experienced muscle weakness, tenderness or loss of muscle mass? ❑ Yes ❑ No

3. Have you experienced unexpected changes in the fingernails or toenails? ❑ Yes ❑ No

4. Have you experienced pain in the muscles of the legs with walking that quickly clears with cessation of activity? ❑ Yes ❑ No

5. Have you experienced color or temperature changes of the hands or feet since your last evaluation? ❑ Yes ❑ No

Central Nervous System:

1. Have you experienced motor or sensory abnormalities of any area of the body? ❑ Yes ❑ No

2. Have you experienced unusual levels of anxiety or depression? ❑ Yes ❑ No

Sleep Patterns:

1. Have you or others noticed that you have difficulties with sleeping? ❑ Yes ❑ No

If yes, please answer the following questions.

Do you have a loud snore? ❑ Yes ❑ No
Do you fight for breath during sleep? ❑ Yes ❑ No
Do you fall asleep in an appropriate time? ❑ Yes ❑ No
Do you feel rested when you wake up? ❑ Yes ❑ No

Other Pertinent Medical Information:

1. Are there any other new additions to your medical history?

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_____

_____

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

*NAME:*_____

*HOME ADDRESS:*_____

E-MAIL ADDRESS: _____

*HOME PHONE:*_____ *WORK PHONE:*_____

*OCCUPATION:*_____

*DATE OF BIRTH:*_____ *S.S.#:*_____

*HOW DID YOU HEAR ABOUT OUR CENTER?*_____