



Information For Your Physician Executive Health Program

Complete BOTH SIDES in blue or black ink only
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Number (above) and Name

Please answer the following questions. It will help your physician to know not only about your health but also about your family and relatives.

Patient Name _____ Clinic Number _____

Today's Date _____ Current Age _____ Place of Birth _____

Race or nationality of parents _____

Are you employed? Yes No Retired If yes, what is your occupation? _____

Have you traveled outside the USA and Canada in the past 5 years? Yes No If yes, where? _____

	Living	Present age or age at death	Significant health problems or cause of death
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Spouse/Domestic Partner	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Present marriage/relationship (years) _____ Previous marriage(s)/relationship(s)(years) _____

Brothers	Number living	_____	Significant health problems	_____
	Number non-living	_____	Cause(s) of death	_____
Sisters	Number living	_____	Significant health problems	_____
	Number non-living	_____	Cause(s) of death	_____
Children	Number living	_____	Significant health problems	_____
	Number non-living	_____	Cause(s) of death	_____

Have there been any changes since your last examination? Yes No Explain _____

Please check illnesses which have occurred in any of your **blood** relatives:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Nervous disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |

Please check illnesses or conditions which **you** have had:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Reflux/peptic ulcer disease | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Other: _____ | |

What type of physical activities do you perform (including Yoga, Tai Chi, etc.)? _____

Do you engage in any other healing or alternative therapies (e.g. acupuncture, massage, hypnosis, etc.)? _____

Previous operations (please list procedure and year)

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

Have you had any serious injuries, broken bones, etc.? Yes No

If yes, please list _____

Have you ever had an allergic reaction to any medications? Yes No

If yes, which medications and what type of reaction? _____

Have you ever had an allergic reaction to X-ray contrast dye? Yes No

If yes, please describe _____

Have you ever had a latex allergy? Yes No

Have you ever had a tape allergy? Yes No





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Tobacco use [] Never [] Now [] In the past How much each day? _____ For how many years? _____
When did you quit? _____
Alcohol use [] Never [] Now [] In the past How much each day? _____ For how many years? _____
When did you quit? _____
Recreational drug use [] Never [] Now [] In the past How much each day? _____ For how many years? _____
When did you quit? _____

Please check the diseases against which you have been immunized:

- [] Tetanus _____ Date of Immunization _____ [] Hepatitis A [] Measles [] German measles (Rubella)
[] Pneumovax _____ Date of Immunization _____ [] Hepatitis B [] Polio [] Influenza
[] Zoster Vaccines [] HPV

Table with 3 columns: Prescription Medications, Dosage (mg), Frequency (once, twice, etc., per day)

Table with 3 columns: Non Prescription Medications (including over-the-counter drugs, supplements, herbs, vitamins, etc.), Dosage (mg), Frequency (once, twice, etc., per day)

Have you taken cortisone-type drugs? [] Yes [] No
Have you ever had blood products transfused? [] Yes [] No If yes, when? _____ where? _____
When was your most recent proctoscopic/sigmoidoscopic/barium enema/colonoscopic exam? _____
What is your usual weight? _____ How long have you been at this weight? _____

Women Only
History of abnormal Pap smear? [] Yes [] No Last menstrual period _____ Last pap smear? _____
Most recent mamogram? _____ Periods are [] regular [] irregular
Number of Pregnancies _____ Number of miscarriages _____

Is there anything else you would like evaluated? (Patient to incur additional cost)
[] No, I do not want any other conditions addressed.

Non-Mayo physician involved in your care:
Name _____
Address _____
City _____ State _____ Zip Code _____
In order to support your continuing care, Mayo Clinic may share a summary of your findings with the above listed physician.