FortMed Medical Clinics

HEALTH QUESTIONAIRE
Executive Physical

Patient Identification

Date:________________________ Physician:______________________________

Please check(✓) the appropiriate column if the patient has or had the following:

#		No	Yes
1	Hearing difficulty		
2	Ringing in the ear		
3	Frequent earaches		
4	Motion sickness		
5	Change in taste senses		
6	Sneezing spells		
7	Sensitive sore tongue		
8	Hoarseness or sore throat		
	(without cold)		
9	Eye problem		
10	Wear corrective lenses		
11	Wheeze or gasp for air		
12	Prolonged episodes of coughing		
13	Cough up a lot of		
	thick mucus		
14	Cough up blood		
15	Shortness of breath		
	at Rest		
	with exercise		
	lying down		
16	Frequent cold		
17	Increased sweating		
18	Aches, pains, or tightnes		
	in your chest		
19	Been light - headed or dizzy		
20	Skin problems		
21	Bruise easily		
22	Abnormal bleeding problem		
23	Numbness or weakness		
	on any side of the body		
24	Ever fainted		
25	Seizure or convulsion		
26	Gained more than 10 pounds		
	in the last year		
27	Loss more than 10 pounds		
	in the last year		
28	Loss appetite		
29	Difficulty swallowing		
30	Indigestion		
31	Excessive belching		
32	Nausea, vomiting		
33	Inflamed veins or blood clots		
	in legs		

#		No	Yes
34	Severe abdominal pain		
35	Constipation		
36	Food intolerance		
37	Frequent diarrhea		
38	Change in bowel habits		
39	Blood in stool		
40	Black stool		
41	Rectal surgery		
42	Bleeding from rectum		
43	Burning pain when urinating		
44	Abnormal urine dissolution		
45	Painful / swollen joints		
46	Painful muscles		
47	Back problems		
48	Recurring pain in feet		
49	Do you have any disabilities		
50	Always hungry		
51	More thirsty lately		
52	Been told to have high blood		
	sugar		
53	Often feel fatigue		
54	Difficulty falling asleep		
55	Swelling in armpits or groins		
56	Hard to remember or concentrate		
57	Feel depressed		
58	Difficulty relaxing		
59	Tendency to worry a lot		
60	Anxious by work or family problem		
61	Ever seen a psychiatrist/		
	psychologist		
62	Frequent headaches		
63	High blood pressure		
64	Smoke cigarettes/ cigars		
	number of years _______		
	Packs per day ________		
65	Drink alcohol/coffee		
	Number of cups / day ______		
	FOR MEN ONLY		
66	Urine stream weak or slow		
67	Prostate trouble		
68	Burning or discharges from		
	your penis		
69	Lumps or swelling in your testicle		
70	Lesions in the genetalia		

#		No	Yes
	FOR WOMEN ONLY		
71	Trouble with menstrual periods		
72	Bleeding between your periods		
73	Exercise flow		
74	Bleeding/pain after intercourse		
75	Bloating or irritability before		
	your periods		
76	Hot flushes		
77	Lumps in your breast		
78	Vaginal discharges/itchiness		
79	Date of last menstrual period		
80	Please indicate the number of		
	miscarriages		
	pregnancies		
	stillbirths		
	premature births		
	cesarean section		
	abortions		
	normal deliveries		
81	List any other special problem		

Explanations:

Form #0033

MEDICAL HISTORY: Place a (✓) next to illness / condition that the patient has or had. Explain below.

- ❑ Allergies
- ❑ Anemia
- ❑ Asthma or Bronchitis
- ❑ Backache
- ❑ Bleeding Tendencies
- ❑ Cancer or Tumor
- ❑ Diabetes
- ❑ Diarrhea or Dysentery
- ❑ Ear Problems
- ❑ Epilepsy
- ❑ Ete Disease
- ❑ Glaucoma
- ❑ Goiter (Thyroid)
- ❑ Hay Fever
- ❑ Hearing Problems
- ❑ Heart Problem
- ❑ Hemorrhoids (Piles)
- ❑ Heredity / Familial Disease
  Specify:____________
- ❑ Hernia
- ❑ High Blood Pressure
- ❑ Kidney / Bladder Problems
- ❑ Liver Disease / Hepatitis
- ❑ Lung Disease
- ❑ Malaria
- ❑ Meningitis
- ❑ Migraine / Headaches
- ❑ Neuralgia / Neuritis
- ❑ Nervous Disorder
- ❑ Pneumonia
- ❑ Polio
- ❑ Pneumatic Fever
- ❑ Skin Disease
- ❑ Stroke
- ❑ Sinusitis
- ❑ Tubercolosis
- ❑ Typhoid Fever
- ❑ Ulcer (Stomach or Doudenal)
- ❑ Vaccinations
- ❑ Veneral Disease
- ❑ Any compensation or Insurance
- ❑ Benefits for Injury / Illness

List any major Illnesses:

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List any hospitalization or surgeries you have had:

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Current Medications:

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EXPLANATION: (S):

Indicate which of the following tests performed on the patient have been abnormal.

- ❑ Resting ECG / Stress Test
- ❑ CT Scan
- ❑ (PFT)
- ❑ TB Work-up
- ❑ Chest X-Ray
- ❑ Genitourinary Studies
- ❑ Upper GI Studies
- ❑ Lower GI Studies
- ❑ Hepatoiliary Studies
- ❑ Biopsy
- ❑ Laboratory Tests
- ❑ Others: ______________________________

FAMILY HISTORY: Have any of your blood relatives (mother, father, aunts, uncles, children) had any of the following:

	NO	YES	If "YES", Specify which relative		NO	YES	If "YES", Specify which relative
Asthma				High blood pressure			
Cancer				Tuberculosis			
Diabetes				Excessive nervousness / mental disorder			
Heart trouble or stroke				Any other condition or disease that run in your family			

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Signature of Physician