

EXECUTIVE PHYSICAL SCREENING QUESTIONNAIRE

Please complete the following information in order for UCLA Medical Center to make an appropriate recommendation as to the type of executive physical program that would be best suited to your medical needs. Please print all information.

Name (Last, First, Middle): _____			
Street Address: _____			Birth date (dd/mm/yy): ____ / ____ / ____
City: _____	State: _____	Zip: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Phone: _____	Fax: _____	Height: _____	Weight: _____

1. Have you had a family history of any of the following diseases (check all that apply):

- a. Colon cancer: if yes, specify (eg. family member, type of problem): _____
- b. Cardiac disease: if yes, specify: _____
- c. Diabetes: _____
- d. High Blood Pressure: _____
- e. Prostate Cancer: _____
- f. Arthritis (such as Lupus or Rheumatoid Arthritis): _____
- g. Other: _____
- h. **FOR WOMEN ONLY:** Breast cancer: if yes, specify treatment, if any: _____
 Osteoporosis: if yes, specify treatment program: _____

2. When was the last time you had any of the following tests and what were the results (If none, leave blank):

- a. Date of last treadmill test ("stress test") _____ Results were: Normal Abnormal
- b. Date of last flexible sigmoidoscopy _____ Results were: Normal Abnormal
- c. Date of last chest X-ray _____ Results were: Normal Abnormal
- d. Date of last eye examination _____ Results were: No eye problems identified
 Needed corrective lenses or new prescription
 Other: please explain _____
- e. **FOR WOMEN ONLY:**
 Date of last Mammography _____ Results were: Normal Abnormal
 Date of last Pap Smear _____ Results were: Normal Abnormal

3. Within the last six months, have you experienced any type of chest pain? Yes No

4. Do you currently of have ever smoked? Yes No

- a. If yes, on average, how many cigarettes do you currently smoke per day? _____
- b. Describe your smoking history (include number of years as a smoker, quantity of cigarettes smoked/day):

5. Have you ever had surgery? No Yes; please specify condition and date(s) of surgery: _____

6. Are you currently being treated for any type of health problem? No Yes; please specify condition, treatment program and prescribed medications: _____

7. Please describe any particular health concerns or symptoms you are currently experiencing:

