UNIVERSITY EXECUTIVE PHYSICAL PROGRAM

Tel: (310) 208-0708 Fax: (310) 209-1577

Patient Information Sheet

First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Home Telephone: ( ) -		
Work Telephone: ( ) - ext.		

MAIL or FAX to:

UNIVERSITY EXECUTIVE PHYSICAL PROGRAM
100 UCLA Medical Plaza, Suite 720
Los Angeles, Ca. 90024-6970
FAX: (310)209-1577

EXECUTIVE PHYSICAL SCREENING QUESTIONNAIRE

Please complete the following information in order for the Executive Physical Program 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:** __Male __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 sigmoidosocopy _____ 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:
_____
_____