

HEALTH HISTORY

(Strictly Confidential)

First Name	Last Name	M	Today's Date
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Date of Birth	Date of last physical exam	What is your reason for visit?
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SYMPTOMS Check (✓) symptoms you currently have had in the past year.

<p style="text-align: center;">GENERAL</p> <input type="checkbox"/> Intolerance to cold <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Daytime drowsiness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Gasp for air or stop breathing while asleep (partner notices) <input type="checkbox"/> Headache <input type="checkbox"/> Intolerance to heat <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness of arms, legs, face <input type="checkbox"/> Excessive or loud snoring <input type="checkbox"/> Sweats <input type="checkbox"/> Swollen glands <input type="checkbox"/> Weakness of arms, legs, face <input type="checkbox"/> Generalized weakness <input type="checkbox"/> Weight gain <input type="checkbox"/> Other	<p style="text-align: center;">GATROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Black stools <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Change in color of stools <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Other	<p style="text-align: center;">EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred or double vision <input type="checkbox"/> Frequent colds <input type="checkbox"/> Change in eye color <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Dry eyes <input type="checkbox"/> Ear ache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Eye discharge <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Itchy eyes <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Painful eyes <input type="checkbox"/> Red eyes <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Frequent sore throat <input type="checkbox"/> Sores in mouth or tongue <input type="checkbox"/> Frequent stuffy/runny nose <input type="checkbox"/> Vision - Flashes or halos <input type="checkbox"/> Frequent sneezing <input type="checkbox"/> Wear corrective eyeglasses <input type="checkbox"/> Wear corrective contact lens <input type="checkbox"/> Other	<p style="text-align: center;">MEN only</p> <input type="checkbox"/> Breast lump or changes <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump or pain in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Change in sexual interest <input type="checkbox"/> Decreased sexual satisfaction <input type="checkbox"/> Sores on penis <input type="checkbox"/> Premature ejaculation								
		<p style="text-align: center;">RESPIRATORY</p> <input type="checkbox"/> Persistent cough <input type="checkbox"/> Bloody cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other									
<p style="text-align: center;">MUSCLE/JOINT/BONE</p> Pain, weakness, numbness in: <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Arms</td> <td><input type="checkbox"/> Hips</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Legs</td> </tr> <tr> <td><input type="checkbox"/> Feet</td> <td><input type="checkbox"/> Neck</td> </tr> <tr> <td><input type="checkbox"/> Hands</td> <td><input type="checkbox"/> Shoulders</td> </tr> </table>		<input type="checkbox"/> Arms	<input type="checkbox"/> Hips	<input type="checkbox"/> Back	<input type="checkbox"/> Legs	<input type="checkbox"/> Feet	<input type="checkbox"/> Neck	<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulders	<p style="text-align: center;">CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain of discomfort <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat/palpitations <input type="checkbox"/> Leg cramps <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <input type="checkbox"/> Other	<p style="text-align: center;">SKIN</p> <input type="checkbox"/> Bruise or bleed easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in nails <input type="checkbox"/> Change in skin color <input type="checkbox"/> Abnormal or excessive hair growth <input type="checkbox"/> Hair loss <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Dry skin <input type="checkbox"/> Sore that won't heal <input type="checkbox"/> Other
<input type="checkbox"/> Arms	<input type="checkbox"/> Hips										
<input type="checkbox"/> Back	<input type="checkbox"/> Legs										
<input type="checkbox"/> Feet	<input type="checkbox"/> Neck										
<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulders										
<p style="text-align: center;">GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <input type="checkbox"/> Other		<p style="text-align: center;">WOMEN only</p> <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> bleeding after menopause <input type="checkbox"/> Breast lump <input type="checkbox"/> Breast pain or tenderness <input type="checkbox"/> Change in mood prior to menstruation <input type="checkbox"/> extreme menstrual pain <input type="checkbox"/> Heavy periods <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Decrease in sexual interest <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other									
		Date of last Menstrual period _____ Age of first menstrual period _____ Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it possible you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No									

There are several tests you can take if you're especially concerned about specific aspects of your health. Please check the box on any test you would like to discuss with the doctor.

EXECUTIVE PHYSICAL PACKAGE

DIAGNOSTIC TESTING

CARDIAC STRESS TEST – Evaluates for blockage in the coronary arteries. Many times, the presence of coronary artery disease is easily missed when a person is at rest, because at rest there may be no sign of a problem either on physical examination or on the ECG. In these cases, cardiac abnormalities may become apparent only when the heart is asked to perform at increased workloads.

BONE DENSITY TEST – This test measures the strength of one's bones and the corresponding risk of fracture or having osteoporosis. Bones can be weakened by age and many clinical conditions, including asthma, rheumatoid arthritis, and celiac or inflammatory bowel disease, as well as personal habits, such as smoking. By knowing one's bone density, we can work to improve it and prevent further bone loss or risk of fracture.

BODY FAT ANALYSIS – This test uses the same technology as the Bone Density test to measure your body composition, including percent body fat and lean body mass. It differentiates between areas of the body and between peripheral fat and the more hidden fat that surrounds body organs.

SPIROMETRY – This breathing test measures your lung capacity and screens for any airway obstruction that may be affecting breathing, such as asthma, chronic bronchitis, or emphysema.

HEARING TEST – Screening to identify hearing loss.

AORTA SCAN – This test screens for an abdominal aortic aneurysm (AAA), which is a weakening of the aortic wall. Anyone who has vascular risk factors, including obesity, smoking, age over 65 or high blood pressure, is at risk for a AAA. Because rupture of a AAA is very dangerous and often fatal, early diagnosis can guide us on how aggressive to be to minimize risk and save lives.

BLADDER SCAN – This test measures residual bladder volume. Too much retained volume may be related to urological symptoms or conditions such as incontinence, frequent or recurrent urinary tract infections, enlarged prostates, or neurologic disorders.

EKG – This test measures the electrical activity of the heart and screens for abnormal rhythms or signs of damage to the heart muscle, such as with heart attacks or heart failure.

EXECUTIVE PHYSICAL PACKAGE (CONTINUED)

LABORATORY TESTING

DIABETES SCREENING – Measures one's blood glucose level and the control of blood sugar over the past three months to identify those who have or are at risk for diabetes.

CARDIAC RISK EVALUATION – Checks one's complete cholesterol panel, along with specialized lipid tests and markers of cardiac inflammation, all of which check one's risk for heart disease and stroke.

KIDNEY HEALTH – Measures one's blood electrolytes, creatinine level, and kidney function including any spillage of microproteins into the urine. Kidney health is important for blood pressure, detoxification, and the body's water balance.

LIVER HEALTH – Measures the function of one's liver cells, including metabolism, detoxification, and helping your blood clot appropriately. Also screens for exposure to Hepatitis C.

IMMUNE SYSTEM HEALTH – Checks one's levels of white blood cells and measures any immune-related body inflammation. Also screens for exposure to HIV.

MEN'S HEALTH – Screens for low testosterone which may affect one's energy, libido, and metabolism. Also checks one's PSA level, which may be related to risk for prostate cancer.

THYROID DISORDER SCREENING – Checks the function of one's thyroid gland which regulates metabolism.

CELIAC DISEASE SCREENING – Screens for celiac disease, which results in one's inability to eat gluten-containing foods. Gastrointestinal symptoms such as bloating, upset stomach, or diarrhea may be signs of underlying celiac disease.

GOUT SCREENING – Checks one's blood uric acid level which is an indicator of one's risk for developing gout arthritis.

BASIC VITAMINS AND MINERALS – Measures the blood levels of Vitamin B12, D, folic acid, and magnesium. Also measures the body's iron levels and storage capacity for iron.

ADDITIONAL TESTS

- ❑ MICRONUTRIENT TEST – measures how micronutrients are actually functioning within your body's cells by evaluating over 33 vitamins, minerals, amino acids and antioxidants, all of which play an important role in overall health and wellness. It allows us to nutritionally assess for deficiencies and how any of these relate to a broad variety of clinical conditions including arthritis, cancer, cardiovascular risk, diabetes, immunological disorders, and metabolic disorders.
- ❑ FOOD SENSITIVITY TESTING – Tests over 150 different foods to see if one is sensitive to them. Food sensitivity may cause chronic symptoms such as digestive problems, migraines, chronic fatigue, aching muscles and joints, rashes and other symptoms. Certain foods may also cause weight gain by causing chronic inflammation. Avoiding those foods may improve the ability to lose weight.
- ❑ GENETIC TEST – Scans your entire genome, assessing your risk of 27 different diseases by identifying your genetic predisposition for common health conditions, enhancing information from your family history and improving medical insights into difficult-to-diagnose diseases.
- ❑ GENETIC TESTING FOR WEIGHT LOSS – This genetic test gives us a personalized metabolism, diet, nutrition, and exercise report based on your specific DNA. It tells us which of 75+ genes you have that predispose you to obesity, unhealthy eating behaviors, food reactions, and what are the most effective diet and exercise types specifically for your body to help you lose weight and reduce the risk of diabetes, blood pressure and high cholesterol. It also lists which vitamins and minerals you are most likely to become deficient in and need replacing. This can be used to formulate a specific diet and exercise plan, using your genetic information to maximize results!
- ❑ BIOPHYSICAL TEST – This blood test covers over 120 disorders including autoimmune diseases, certain cancers, risk for heart disease, stroke and other vascular diseases, blood pressure, diabetes, hormone imbalance, organ function and various infectious diseases.
- ❑ COMPREHENSIVE DIGESTIVE STOOL ANALYSIS – Evaluates digestion, absorption, gut flora and the colonic environment. Evaluates for parasites and infections. This test is excellent for anyone with chronic GI problems or a change in bowel patterns.
- ❑ TOXIC CORE - This laboratory profile measures levels of 45 different toxic chemicals in your body due to exposure to these in foods, air, and the environment. Toxic chemicals can be present in the body without any obvious symptoms but over time, these are associated with many chronic health conditions, including autoimmune diseases, hormonal imbalances, and even cancer. By identifying your levels, we can help eliminate toxins from your body and reduce or prevent more harmful exposures.
- ❑ TELOMERE TESTING – Telomeres are sections of DNA at the end of each chromosome that serve as a cap to your genetic material. Shorter telomeres imply a shorter lifespan for a cell. Therefore, this test can give you your “biological” age.

- ❑ ESTROGEN PROFILE - This test determines which types of estrogens and their metabolites are present in a woman's body. These levels influence a woman's risk of developing breast cancer. By modulating the levels one can reduce the risk of breast cancer.

- ❑ STRESS HORMONE PROFILE - This test determines the levels of stress hormones and their precursors to see if the adrenal glands are working normally, are excessively stimulated or are burned out. Adrenal gland relaxers or supporters may be used to restore adrenal gland balance.

- ❑ BRCA TEST – Recommended for those with a strong family history of breast ovarian cancer.

- ❑ CIMT - This test screens for atherosclerosis, the build-up of cholesterol and inflammation within the arterial wall. This is the earliest stage of fatty plaque development, even before the atherosclerotic plaque enters and obstructs the artery blood flow, and well before an actual stroke or heart attack occurs. The thickness of the artery wall is one of the earliest and most reliable indicators of cardiovascular disease.

At Coral Gables Executive Physicians, we want our patients to have access to the highest quality pharmaceutical-grade natural supplements available in the market today. Many of these products can improve quality of life and reduce the risk of many chronic diseases that may shorten one's life span. We have researched what we feel are the top products from several different nutraceutical companies.

For every order we place, a portion of the proceeds is donated to a charity, educational institution or cause of our choosing in the name of Coral Gables Executive Physicians. We do not make a profit on the sale of any of these products. We offer this service so that our patients do not have to go elsewhere to obtain high-quality natural supplements while benefiting our community in the process.

Please check the list below for any products you might be interested in and mark the appropriate box so that we may give you more information.

- Safely **decreasing fat** mass while increasing muscle mass
- Reduce the risk of **cancer**
- Lower **cholesterol** levels
- Decrease **wrinkles**, strengthen **nails**, grow **hair**
- Reduce menopausal **hot flashes** by up to 70%
- Easy to take supplements that provide the daily recommendation of **fruits** and/or **vegetables** for those that don't get 7-10 servings daily in their diet
- Meal replacement products and **protein** supplements
- The highest quality **omega-3** fish oils
- General **multivitamin** supplementation
- Reduce the effects of **stress** on the body
- Reduce the risk of developing **dementia**
- Strengthen the **immune system**
- Antioxidant** supplements which may reduce the risk of conditions such as cancer, heart disease and neurologic conditions
- Reduce the symptoms of premenstrual syndrome (**PMS**)
- Anti-aging** regimen for those interested in slowing the aging process

Sleep Apnea Questionnaire

Completely fill in one circle for each question - answer all questions

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	<input type="radio"/> Yes	<input type="radio"/> No	Stroke	<input type="radio"/> Yes	<input type="radio"/> No
Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No	Depression	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes	<input type="radio"/> No
Lung Disease	<input type="radio"/> Yes	<input type="radio"/> No	Nasal oxygen use	<input type="radio"/> Yes	<input type="radio"/> No
Insomnia	<input type="radio"/> Yes	<input type="radio"/> No	Restless leg syndrome	<input type="radio"/> Yes	<input type="radio"/> No
Narcolepsy	<input type="radio"/> Yes	<input type="radio"/> No	Morning Headaches	<input type="radio"/> Yes	<input type="radio"/> No
Sleeping Medication	<input type="radio"/> Yes	<input type="radio"/> No	Pain Medication e.g., vicodin, oxycontin	<input type="radio"/> Yes	<input type="radio"/> No

Co-morbidities
+1 for each Yes
response

Score

Do not assign
any points for
these eight
responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0=would never doze 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

	0	1	2	3
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting, inactive, in a public place (theater, meeting, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Epworth Score
TOTAL the
values from all
8 questions,
if 11 or less
Score=0
If 12 or more
Score=2

Score

Frequency 0-1 times/week 1-2 times/week 3-4 times/week 5-7 times/week

On average in the past month, how often have you snored or been told that you snored?	Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4
Do you wake up choking or gasping?	Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4
Have you been told that you stop breathing in your sleep or wake up choking or gasping?	Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost always <input type="radio"/>

Assign points for
each of the first
three responses

Signature	Area Code	Phone Number	Total all 6 boxes from above if point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	Point Total
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>