CORAL GABLES
EXECUTIVE PHYSICIANS

PATIENT INFORMATION

Date_____ E-Mail _____

Patients Name _____

S.S.N. _____ DOB _____ Sex ◯M ◯F

Address _____ City _____ State____ Zip _____

Home Phone _____ Other Phone _____

EMPLOYMENT INFORMATION

Employer Name _____ Occupation _____

Address _____ City _____ State____ Zip _____

Work Phone _____ Ext. _____

INSURANCE INFORMATION

Primary insurance Company

_____

Address _____ City _____ State____ Zip _____

Phone _____

Insurance ID# _____ Group # _____

Coral Gables Executive Physicians

HEALTH HISTORY

(Strictly Confidential)

First Name	Last Name	M	Today's Date

Date of Birth	Date of last physical exam	What is your reason for visit?

SYMPTOMS Check (√) symptoms you currently have had in the past year.

GENERAL

- ☐ Intolerance to cold
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Daytime drowsiness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Gasp for air or stop breathing while asleep (partner notices)
- ☐ Headache
- ☐ Intolerance to heat
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness of arms, legs, face
- ☐ Excessive or loud snoring
- ☐ Sweats
- ☐ Swollen glands
- ☐ Weakness of arms, legs, face
- ☐ Generalized weakness
- ☐ Weight gain
- ☐ Other

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Other

GATROINTESTINAL

- ☐ Appetite poor
- ☐ Black stools
- ☐ Bloating
- ☐ Bowel changes
- ☐ Change in color of stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Excessive gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Other

CARDIOVASCULAR

- ☐ Chest pain of discomfort
- ☐ High blood pressure
- ☐ Irregular heart beat/palpitations
- ☐ Leg cramps
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Other

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred or double vision
- ☐ Frequent colds
- ☐ Change in eye color
- ☐ Difficulty swallowing
- ☐ Dry eyes
- ☐ Ear ache
- ☐ Ear discharge
- ☐ Eye discharge
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Itchy eyes
- ☐ Nosebleeds
- ☐ Painful eyes
- ☐ Red eyes
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Frequent sore throat
- ☐ Sores in mouth or tongue
- ☐ Frequent stuffy/runny nose
- ☐ Vision - Flashes or halos
- ☐ Frequent sneezing
- ☐ Wear corrective eyeglasses
- ☐ Wear corrective contact lens
- ☐ Other

SKIN

- ☐ Bruise of bleed easily
- ☐ Hives
- ☐ Itching
- ☐ Change in nails
- ☐ Change in skin color
- ☐ Abnormal or excessive hair growth
- ☐ Hair loss
- ☐ Rash
- ☐ Scars
- ☐ Dry skin
- ☐ Sore that won't heal
- ☐ Other

MEN only

- ☐ Breast lump or changes
- ☐ Erection difficulties
- ☐ Lump or pain in testicles
- ☐ Penis discharge
- ☐ Change in sexual interest
- ☐ Decreased sexual satisfaction
- ☐ Sores on penis
- ☐ Premature ejaculation

RESPIRATORY

- ☐ Persistent cough
- ☐ Bloody cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Other

WOMEN only

- ☐ Bleeding between periods
- ☐ bleeding after menopause
- ☐ Breast lump
- ☐ Breast pain or tenderness
- ☐ Change in mood prior to menstruation
- ☐ extreme menstrual pain
- ☐ Heavy periods
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Decrease in sexual interest
- ☐ Vaginal discharge
- ☐ Other

Date of last Menstrual period _____

Age of first menstrual period _____

Are you pregnant? ◯ Yes ◯ No

Is it possible you are pregnant?

◯ Yes ◯ No

CONDITIONS Check (√) conditions you have had in the past.

- ☐ Abnormal Pap Smear
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bleeding ulcer
- ☐ Blood clot (Thrombosis)
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Hypertension (High blood pressure)
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Skin cancer
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tension Headaches
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Urinary infections
- ☐ Vaginal infections
- ☐ Venereal Disease

MEDICATIONS List any prescription, over the counter or herbal or alternative medications you are currently taking, the doses and what you are taking them for. List the approximate date the medication was started. Note if you are experiencing any side effects you believe are related to that medication. Please add a notation if any of the prescription medications were not prescribed specifically for you.	**ALLERGIES or ADVERSE REACTIONS To medications or substances List the type and severity of reaction Note that these medications do not necessarily pertain to the list on the left.**

PRIOR MEDICATIONS List any prescription, over the counter or herbal or alternative medications that you have taken in the the past. List the approximate dates that you took them, the doses and the reason you took them. To the right, explain why the medication was stopped.	**REASON FOR MEDICATION CHANGE OR STOPPAGE Note that these comments should pertain to the medication directly to the left.**

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Children				

Check (√) if, your blood relatives had any of the following:

(√)	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	High Cholesterol	
	Stroke	
	Anemia	
	Mental Illness	
	Other	

HOSPITALIZATION/SURGERIES

Dates	Hospital	Reason for Hospitalization/Surgery and Outcome

PREGNANCY HISTORY

Include abortions and miscarriages as well as live births. If any miscarriages, note which trimester and if the reason for the miscarriage was known.

Year of Birth	Sex of Child	Complications, if any		

Have you been bitten by a tick in the last year? ☐ Yes ☐ No

Have you ever, even once, shared needles with another person for any purpose? ☐ Yes ☐ No

Have you traveled outside the country in the last year? ☐ Yes ☐ No
if so, where?

Have you had any recent exposure to any animals other than dogs or cats? ☐ Yes ☐ No if so, what animal?

Have you ever had a blood transfusion? ◯ Yes ◯ No
if yes, please give approximate dates._____

HEALTH HABITS Check (√) which substances you use and describe how much you use. If use is not current, indicate this and note the dates and amounts.

☐	Caffeine	
☐	Tobacco	
☐	Drugs	
☐	Alcohol	
☐	Other	

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS Check (√) if you work exposes you to the following:

☐	Hazardous Substances
☐	Heavy Lifting
☐	Other

Your occupation:

How many different sexual partners have you had in the last year?

if more than one sexual partners, how are you practicing safe sex?

Females only. Do you use birth control? ☐ Yes ☐ No

If so, which type?

Females only. Do you perform self breast exams? ☐ Yes ☐ No

☐ Yes ☐ No

Have you been threatened or assaulted by someone close to you?

PREVENTIVE SCREENING	DATE of LAST TEST	RESULTS
Colonoscopy		
Mammogram		
Pap Smear		
Prostate cancer (PSA)		
Bone density		
Cholesterol		
Eye exam		
Dental exam and cleaning		
Chest X-ray		
EKG		
Stress Test		
VACCINATIONS	**LAST SHOT**	**ADVERSE REACTIONS?**
Influenza (flu shot)		
Pneumonia vaccine		
Tetanus		
Hepatitis A		
Hepatitis B		
Meningitis		
Chicken pox		

CORAL GABLES
EXECUTIVE PHYSICIANS
INTERNAL MEDICINE

550 Biltmore Way · Suite 101
Coral Gables, FL 33134
Phone 305.446.9940 · facsimile 305.446.0861

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.

CORAL GABLES EXECUTIVE PHYSICIANS
INTERNAL MEDICINE

550 Biltmore Way · Suite 101
Coral Gables, FL 33134
Phone 305.446.9940 · facsimile 305.446.0861

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

CORAL GABLES
EXECUTIVE PHYSICIANS
INTERNAL MEDICINE

550 Biltmore Way · Suite 101
Coral Gables, FL 33134
Phone 305.446.9940 · facsimile 305.446.0861

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	❍ Yes	❍ No	Stroke	❍ Yes	❍ No
Heart Disease	❍ Yes	❍ No	Depression	❍ Yes	❍ No
Diabetes	❍ Yes	❍ No	Sleep Apnea	❍ Yes	❍ No
Lung Disease	❍ Yes	❍ No	Nasal oxygen use	❍ Yes	❍ No
Insomnia	❍ Yes	❍ No	Retless leg syndrome	❍ Yes	❍ No
Narcolepsy	❍ Yes	❍ No	Morning Headaches	❍ Yes	❍ No
Sleeping Medication	❍ Yes	❍ No	Pain Medication e.g., vicodin, oxycontin	❍ Yes	❍ No

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepines 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 fo each situation. (M.W. Johns, Sleep 1991)

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

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

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 3-4times/week 5-7 times/week

Assign points for each of the first three responses

On average in the past month, how often have you snored or been told that you snored?

Never ❍ Rarely ❍ +1 Sometimes ❍ +2 Frequently ❍ +3 Almost always ❍ +4

Do you wake up choking or gasping?

Never ❍ Rarely ❍ +1 Sometimes ❍ +2 Frequently ❍ +3 Almost always ❍ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never ❍ Rarely ❍ +1 Sometimes ❍ +2 Frequently ❍ +3 Almost always ❍ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ❍ Rarely ❍ Sometimes ❍ Frequently ❍ Almost always ❍

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

CORAL GABLES
EXECUTIVE PHYSICIANS
INTERNAL MEDICINE

550 Biltmore Way · Suite 101
Coral Gables, FL 33134
Phone 305.446.9940 · facsimile 305.446.0861

Are you living with Adult ADHD?

The questions below can help you find out.

Many adults have been living with Adult-Attention-Deficit/Hyperactivity Disorder (Adult ADHD) and don't recognize it. Why? Because its symptoms are often mistaken for a stressful life. If you've felt this type of frustration most of your life, you may have Adult ADHD - a condition your doctor can help diagnose and treat.

The following questionnaire can be used as a starting point to help you recognize the signs/symptoms of Adult ADHD but is not meant to replace consultation with a trained healthcare professional. An accurate diagnosis can only be made through a clinical evaluation. Regardless of the questionnaire results, if you have concerns about diagnosis and treatment of Adult ADHD , please discuss your concerns with your physician.

The Adult Self-Report Scale V1.1 (ASRS-V1.1) Screener is intended for people aged 18 years or older.

Adult Self-Report Scale-V1.1 (ASRS-V1.1) Screener
from WHO Composite International Diagnostic Interview
© World Health Organization

Check the box that best describes how you have felt and conducted yourself over the past 6 months. Please give the completed questionnaire to your healthcare professional during your next appointment to discuss the results.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Add the number of checkmarks that appear in the darkly shaded area. Four (4) or more checkmarks indicate that your symptoms may be consistent with Adult ADHD. It may be beneficial for you to talk with your healthcare provider about an evaluation.