



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 # _____

Health History Form

Confidential

Patient Information:

First Name: _____ Last Name: _____ M.I.: _____

DOB: _____ Today's Date: _____ Last Physical: _____

Reason for Visit: _____

Symptoms (check all that apply)

<p>General Wellness</p> <ul style="list-style-type: none"> <input type="radio"/> Fatigue/daytime drowsiness <input type="radio"/> Sleep issues <input type="radio"/> Mood changes <input type="radio"/> Memory issues <input type="radio"/> Weight changes <input type="radio"/> Heat/cold <input type="radio"/> Dizziness/fainting <input type="radio"/> Weakness/fatigue <input type="radio"/> Other: _____ 	<p>Digestive Health</p> <ul style="list-style-type: none"> <input type="radio"/> Appetite changes <input type="radio"/> Bloating/gas <input type="radio"/> Heartburn <input type="radio"/> Constipation <input type="radio"/> Diarrhea <input type="radio"/> Nausea/vomiting <input type="radio"/> Hemorrhoids <input type="radio"/> Rectal bleeding <input type="radio"/> Difficulty swallowing <input type="radio"/> Other: _____ 	<p>ENT & Vision</p> <ul style="list-style-type: none"> <input type="radio"/> Colds <input type="radio"/> sore throat <input type="radio"/> Vision changes <input type="radio"/> Ear ringing <input type="radio"/> Hearing loss <input type="radio"/> Nosebleeds <input type="radio"/> sinus issues <input type="radio"/> Mouth sores <input type="radio"/> gum bleeding <input type="radio"/> Other: _____ 	<p>Men's Health:</p> <ul style="list-style-type: none"> <input type="radio"/> Breast change <input type="radio"/> Erectile/sexual concerns <input type="radio"/> Testicular pain/lumps <input type="radio"/> Penis discharge/sores <input type="radio"/> Other: _____ 	
<p>Respiratory:</p> <ul style="list-style-type: none"> <input type="radio"/> Persistent cough <input type="radio"/> Bloody cough <input type="radio"/> Wheezing <input type="radio"/> Shortness of breath <input type="radio"/> Other: _____ 	<p>Cardiovascular:</p> <ul style="list-style-type: none"> <input type="radio"/> Chest discomfort <input type="radio"/> Palpitations <input type="radio"/> High/low BP <input type="radio"/> Swelling ankles <input type="radio"/> Poor circulation <input type="radio"/> Varicose veins <input type="radio"/> Other: _____ 	<p>Muscles & Joints (pain/weakness/numbness):</p> <ul style="list-style-type: none"> <input type="radio"/> Neck <input type="radio"/> Shoulders <input type="radio"/> Arms <input type="radio"/> Hands <input type="radio"/> Back <input type="radio"/> Hips <input type="radio"/> Legs <input type="radio"/> Feet 	<p>Women's Health:</p> <ul style="list-style-type: none"> <input type="radio"/> Breast changes <input type="radio"/> Menstrual irregularities <input type="radio"/> Hot flashes <input type="radio"/> Vaginal symptoms <input type="radio"/> Sexual health concerns <input type="radio"/> Other: _____ <input type="radio"/> Last Period: _____ <input type="radio"/> Age at First Period: _____ <input type="radio"/> Pregnant: Yes/No 	
<p>Skin & Hair:</p> <ul style="list-style-type: none"> <input type="radio"/> Rash/itching/hives <input type="radio"/> Hair loss <input type="radio"/> Nail/skin color changes <input type="radio"/> Bruising/slow healing <input type="radio"/> Other: _____ 				<p>Genito-Urinary:</p> <ul style="list-style-type: none"> <input type="radio"/> Frequent urination <input type="radio"/> Painful urination <input type="radio"/> Blood in urine <input type="radio"/> Bladder control issues <input type="radio"/> Other: _____
<p>Notes:</p> 				

Medical History- Check (✓) conditions you have had in the past:

<input type="checkbox"/> Abnormal Pap Smear	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> AIDS	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Cancer	<input type="checkbox"/> Urinary Infections
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Polio	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Prostate Issue	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hypertension (High BP)	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tension Headaches	<input type="checkbox"/> Hernia
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Ulcer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Blood Clot (Thrombosis)
Others					

MEDICATIONS		ALLERGIES or adverse reactions	
List any prescription, supplement and OTC			
Prior Medications		Reason to stop	

Family History – Fill in health information about your family.

Relation	Age	State of Health	Age of death/Cause
Father			
Mother			
Brothers			
Sisters			
Children			

Diseases in family

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 _____

Hospitalizations/Surgeries			Pregnancy History		
Dates	Hospital	Reason	Year of Birth	Sex	Complications?
Serious Illness/Injuries			Occupational concerns		
			<input type="radio"/> Hazardous substances <input type="radio"/> Heavy Lifting <input type="radio"/> Other		

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

Have you ever shared needles with another person for any purpose? Yes No

Have you traveled outside the country in the last year? Yes No

Health Habits	Frequency	
Tabacco		
Alcohol		
Drugs		
Animal exposure other than dog/cats		
Occupational Hazard?		

Medical History and Preventive Screening

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

If more than one sexual partner, how are you practicing safe sex? _____

Have you been threatened or assaulted by someone close to you? Yes No

Females only: Do you use birth control? Yes No If so, which type? _____

Do you perform self breast exams? Yes No

Preventive Screening

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

Vaccination	Last Shot	Adverse Reactions?
Influenza (flu shot)		
Pneumonia vaccine		
Tetanus		
Hepatitis A		
Hepatitis B		
Meningitis		
Chicken pox		



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. 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 from the sale of any of these products. 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

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"/>

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"/>

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 style="width: 30px; height: 30px;" type="text"/>

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

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

Score

Assign points for each of the first three responses

Point Total

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.

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?

	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.

The 6-question Adult Self-Report Scale-Version 1.1 (ASRS-V1.1) Screener is a subset of the WHO's 18-question Adult ADHD Self-Report Scale-Version 1.1 (Adult ASRS-V1.1) Symptom Checklist. ASRS-V1.1 Screener COPYRIGHT© 2003 World Health Organization (WHO). Reprinted with permission of WHO. All rights reserved.

At CGEP, we go far beyond the standard physical. Our advanced diagnostic menu gives you a **comprehensive, data-driven picture of your health** — detecting disease earlier, identifying hidden risks, and empowering you to make better decisions for your future.

B L O O D , I M M U N E & M E T A B O L I C

Biophysical Test

Covers 120 disorders — autoimmune diseases, cancers, heart disease, stroke, diabetes, hormone imbalance, organ function, and infectious diseases.

Micronutrient Test

Measures 33+ vitamins, minerals & antioxidants at the cellular level. Identifies deficiencies linked to arthritis, cancer, diabetes & more.

Stress Hormone Profile

Evaluates adrenal gland function — detecting overload or burnout — and guides targeted hormonal restoration.

C A N C E R D E T E C T I O N & G E N E T I C S

Galleri — Multi-Cancer Screen

Detects signals for 50+ types of cancer with a single blood draw. Identifies where in the body the signal originates. Recommended for elevated-risk adults.

Natera — Hereditary Cancer

Screens 53 genes associated with 12+ hereditary cancers. Guides screening frequency, informs treatment decisions, and alerts family members.

New Amsterdam — Full Genome

Analyzes all 22,000 human genes for mutations. Delivers personalized diet, exercise & lifestyle recommendations based on your unique DNA.

C A R D I O V A S C U L A R

CIMT

Ultrasound detecting arterial wall thickening — the earliest sign of cardiovascular disease — well before a stroke or heart attack occurs.

Echocardiogram

Advanced 30-minute noninvasive cardiac imaging. Diagnoses heart failure and valve disorders. Results reviewed by a board-certified cardiologist.

ECG Monitor — Up to 14 Days

Compact, wireless, wearable. Captures EKG data for up to 14 days with high clinical accuracy. Diagnoses palpitations, dizziness & arrhythmias.

24-Hour BP Monitor

Continuous blood pressure tracking day and night. Accurately diagnoses hypertension or hypotension missed by single office readings.

G U T H E A L T H & D I G E S T I O N

Food Sensitivity Testing

Evaluates sensitivity to 150+ foods. Identifies triggers for digestive issues, migraines, fatigue, joint pain, rashes & weight gain from chronic inflammation.

P88 Dietary Antigen

Measures four immune reactions (IgE, IgG, IgG4, complement) to 88 foods. Ranks each food by reactivity and provides personalized diet plans.

Comprehensive Stool Analysis

Evaluates digestion, absorption, gut flora & the colonic environment. Tests for parasites and infections. Ideal for chronic GI issues or changes in bowel patterns.

Intestinal Barrier Assessment

Measures Zonulin, DAO, Histamine, LPS IgG & LPS IgA. Diagnoses leaky gut and tracks improvement across the three primary permeability pathways.

SIBO — Bacterial Overgrowth

Breath test detecting hydrogen & methane levels. Identifies small intestinal bacterial overgrowth, a common cause of bloating and chronic GI distress.

T O X I N S & E N V I R O N M E N T A L E X P O S U R E

Toxin Profile

Screens 173 environmental pollutants from a single urine sample. Linked to heart disease, autoimmune disorders, chemical sensitivity, and cancer.

Mycotox Profile — Mold

Screens for 11 mycotoxins from 40 species of mold in one urine sample. Mold toxins are among the most prevalent environmental toxins affecting chronic health.

Heavy Metal Urinalysis

Analyzes 20+ heavy metal toxicants including mercury & lead. Assesses total body burden and toxic overload affecting cardiovascular & neurological health.

Airborne Allergy Panel

Measures IgE reactions to 85 environmental allergens — far more comprehensive than standard inhalant allergy tests.