PLEASE PRINT & COMPLETE THIS QUESTIONNAIRE NOW
AND BRING IT WITH YOU FOR YOUR APPOINTMENT

Executive Health CHECK

Executive Medical & Health Check Questionnaire
Fox Valley Medical Centre, SAH

This is not a test. It is just a method we use to obtain helpful information about your health history and background. We know that it is hard to remember some things, but go ahead and do the best you can.

All information will be kept confidential and will only be used to help us advise you personally or for statistical (de-identified) research purposes.

Please complete the following and print clearly. **Email essential to receive final report. See page 13 for consent on use of email address.

Demographic/Personal Information

Preferred Title Mr/Mrs/Ms/Miss/Dr/_____

Surname _____

1st Name & Initial _____

Preferred Name _____

Address _____

_____

Suburb _____

State _____ Postcode _____

Country (if not Australia) _____

Assessment company-sponsored Yes / No

Home Phone _____

Business Phone _____

Mobile Phone _____

**Email_____

_____

Occupation_____

Company_____

Date of Birth ____/____/19_____

Age _____yrs Gender M☐ F☐

Married/Single/Defacto/Divorc/Sep/Widow

Name & Address of Company to be invoiced _____

_____

Office Use ONLY MRN

FAMILY HISTORY QUESTIONS

On each line tick the box with the correct answer Yes or No ☑

Do you have a <u>family history</u> of:	**YES**	**NO**	Please list whom and at what age it began. Exclude cousins include grandparents,a&uncles
Diabetes	☐	☐	
High cholesterol	☐	☐	
Hypertension/High blood pressure	☐	☐	
(mini)Stroke/TIA/cerebral haemorrhage	☐	☐	
Heart attack/Bypass/stent or angioplasty	☐	☐	
Breast cancer	☐	☐	
Bowel cancer	☐	☐	
Prostate cancer	☐	☐	
Glaucoma/cataract/macular degeneration	☐	☐	
Asthma/emphysema/chronic bronchitis	☐	☐	
Gout or kidney stones	☐	☐	
Death under age 60	☐	☐	Cause:
Other cancers eg lung,kidney,ovarian,etc	☐	☐	List:

PERSONAL MEDICAL HISTORY QUESTIONS

On each line tick the box with the correct answer Yes or No ☑

Have YOU ever had:	**YES**	**NO**	Please list year of diagnosis	
Diabetes or high blood sugar	☐	☐		
High cholesterol	☐	☐	Last reading:	Year:
High blood pressure (hypertension)	☐	☐		
Heart attack/Bypass/stent or angioplasty	☐	☐		
(mini)Stroke/TIA/brain haemorrhage	☐	☐		
Breast cancer	☐	☐		
Bowel cancer	☐	☐		
Prostate cancer	☐	☐		
Other cancer eg lung,kidney,ovarian,etc	☐	☐	List:	
Other serious diagnosed health problem eg emphysema, haemochromatosis, angina, rheumatoid arthritis	☐	☐	Diagnosis:	

PERSONAL MEDICAL HISTORY CONTINUED

On each line tick the box with the correct answer Yes or No ☑

	YES	NO	Additional information
Have YOU ever had:			
An operation or General Anaesthetic	☐	☐	
Illness requiring hospital admission	☐	☐	
Illness lasting more than 5 days	☐	☐	
More than 3 doctors visits in last year	☐	☐	Why?
Chronic problem such as (*circle or add*) -Asthma, ulcer, gout, kidney disorder, epilepsy or _____	☐	☐	
Infection such as (***circle or add***) - Rheumatic fever, Hepatitis, Glandular fever, Malaria, chest infection, bladder infection , meningitis or _____	☐	☐	
Chest pain in past year	☐	☐	
Heart-beat irregularity/palpitations	☐	☐	
If **YES** (to above questions) is this chest pain or irregularity related to exercise	☐	☐	
Have YOU ever had:	**YES**	**NO**	
Recent onset of breathlessness or wheezing	☐	☐	
More than 3 sore throats a year needing medical treatment	☐	☐	
Frequent productive cough	☐	☐	
Recurrent indigestion or heartburn needing medical treatment	☐	☐	
Persistent nausea, vomiting or problem swallowing	☐	☐	
Recent persistent change in bowel function	☐	☐	
Difficulty holding or passing urine	☐	☐	
Any abnormal bleeding	☐	☐	
Recurring joint problem needing bed rest or treatment	☐	☐	
Recurring back pain needing bed rest or treatment	☐	☐	
Recurring dizziness	☐	☐	
Recent recurring headaches	☐	☐	

PERSONAL MEDICAL HISTORY CONTINUED

On each line tick the box with the correct answer Yes or No ☑

	YES	NO	Additional information
Have YOU ever had:			
Difficulty hearing (interfering with social or work functions)	☐	☐	
Visual problem or eye disease (other than glasses)	☐	☐	
Skin rash needing medical treatment	☐	☐	
Unusual lump or swelling	☐	☐	
Change in skin spot or mole	☐	☐	
Visits to any specialists eg dermatologist	☐	☐	Names:
Anxiety, depression or stress needing time off or medical treatment	☐	☐	
Excessive unexplained tiredness	☐	☐	
Weight change (> 5kg since age 25)	☐	☐	
Your approx weight 10 years ago	____ Kilos		
Your weight 1 year ago	____ Kilos		

	YES	NO	
Lived or worked in a developing country	☐	☐	
Worked with chemicals, dusts or sprays	☐	☐	
Is there anything else you would like to add	☐	☐	List:

	YES	NO	
Do you wish any additional tests (at extra cost) eg. HIV, Hep A B or C,thyroid function (Medicare rebates may apply)	☐	☐	List:
Have you had any travel vaccinations?	☐	☐	Year/Type
Do you have any known Allergies?	☐	☐	To what?
Are you on any <u>Medications</u> (incl dosage) or supplements eg fish oil, glucosamine, vitamins, Chinese herbs.	☐	☐	List:

PERSONAL MEDICAL HISTORY CONTINUED

SLEEP (EPWORTH SLEEPINESS SCALE)

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would affect you.

Use the following scale to choose the most appropriate number for each situation:

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

Situation	**Chance of dozing** (circle)			
Sitting and reading……..	**0**	**1**	**2**	**3**
Watching TV……..	**0**	**1**	**2**	**3**
Sitting inactive in a public place (e.g. a theatre or meeting)……..	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break……..	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit…..	**0**	**1**	**2**	**3**
Sitting and talking to someone……..	**0**	**1**	**2**	**3**
Sitting quietly after a lunch without consuming alcohol……..	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic e.g. red light……	**0**	**1**	**2**	**3**

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Questions for Women Only rest of this page

On each line write the correct number in the box ☐

Additional information

How many pregnancies have you had ☐

How many live births ☐

How many births required Caesar-Section ☐ ☐ Or forceps

On each line tick the box with the correct answer *Yes* or *No* ☑

	YES	**NO**	Additional information
Do you have unduly heavy periods	☐	☐	
Have your periods ceased	☐	☐	
Do you take HRT or the OC pill	☐	☐	
Is vaginal discharge a problem	☐	☐	
Do you have a breast lump or pain	☐	☐	
Is PMT a problem	☐	☐	
Except childbirth,ever seen Gynaecologist	☐	☐	

On each line tick the box with the correct answer Yes or No ☑

	YES	**NO**		
Do you have regular Pap Tests?	☐	☐	Year of last?	
If yes, have they always been Normal?	☐	☐		
Do you have regular breast check or ever had Breast Ultrasound or Mammogram?	☐	☐	Year of last?	
Has a breast lump ever been found?	☐	☐	Year?	Treatment

LIFESTYLE CONTINUED

Tick the box with the correct answer ☑ Or write the correct number in the box ☐

SMOKING

Are you currently smoking? **No** ☐ **Yes** ☐

If YES: How many cigarettes/cigars do you smoke per day ____ per day

What age did you start smoking? ____ yo

Are you an occasional smoker eg weekends/social events?

Go to Next Section on ALCOHOL

If NO: Were you a regular smoker in the past? **Yes** ☐ **No** ☐

Go to Next Section on ALCOHOL

If YES: Approximately how many cigarettes or cigars did you smoke daily ____ per day

For how many years did you smoke ____ years

How many years ago did you stop smoking ____ years

Tick the box with the correct answer ☑ Or write the correct number in the box ☐

ALCOHOL

Do you usually have more than 2 drinks of alcohol <u>per week</u>? **Yes** ☐ **No** ☐

Go to Next Section on Page 7

If YES: On how many days of the week do you usually drink ____ days

When you drink how many of the following would you usually have on that <u>ONE day</u>?

Nips of SPIRITS ____ nips

Glasses of WINE ____ glasses

Middies of BEER ____ middies

Cans, stubbies or schooners of BEER ____ cans etc

Cans, stubbies or schooners of LIGHT BEER ____ cans etc

If you drink periodically or in bouts do you think you have too many (eg you feel unsteady, unable to drive etc)? How often? eg weekly **Yes** ☐ **No** ☐

LIFESTYLE QUESTIONS

Tick the box with the correct answer ☑ *Or write the correct number in the box* ☐

PHYSICAL ACTIVITY

Which statement best describes your daily activity levels?

Constantly moving, lifting and carrying, with high levels of activity ☐ **or**

Some walking or driving around with moderate levels of activity ☐ **or**

Usually standing or sitting with low levels of activity most days ☐

Do you have a <u>regular exercise program</u>?

Yes ☐ ↓

No ☐ ↓ **Go to Next Section on SLEEP**

If YES:

How many *days of the week* do you usually exercise ☐ Days

For how many minutes do you usually exercise each time ☐ Mins.

During your <u>regular exercise program</u> at what level do you usually exercise?

Constant high levels of activity (such as running, brisk walking, cycling, aerobics, swimming etc) ☐ **or**

Moderate levels of activity (such as medium walking, cricket, tennis etc) ☐ **or**

Low levels of activity (such as strolling, gardening, golf or bowls) ☐

On each line tick the box with the nearest correct answer ☑

SLEEP (Rest)	**Yes**	**Some Times**	**No**
Do you usually get a satisfactory night's sleep?	☐	☐	☐
Do you get at least 7 hours sleep on most (6 of 7) nights?	☐	☐	☐
Do you usually wake up refreshed?	☐	☐	☐
Do you or your partner notice that you snore during sleep?	☐	☐	☐
If yes, does your partner notice you stop breathing during sleep?	☐	☐	☐
Do you fall asleep during daytime at inappropriate times eg while talking to a friend, stopped in traffic, during important meetings?	☐	☐	☐
Do you usually take sometime in every day to relax eg meditate?	☐	☐	☐
Do you use sleeping tablets(incl herbal) more than 3 times a month	☐	☐	☐

LIFESTYLE CONTINUED

Tick the number between 1 and 5 ☑ *which most closely describes your feelings in the following situations. Eg in first situation box 5 indicates that you feel tense or anxious when late*

	1	2	3	4	5	
When I am late for an appointment *:*						
I still feel relaxed	☐	☐	☐	☐	☐	I feel tense or anxious
When I have a lot to do:						
I feel able to tackle one thing at a time	☐	☐	☐	☐	☐	I feel frustrated or pressured
In my daily activities:						
I seldom feel pushed for time	☐	☐	☐	☐	☐	I usually feel rushed
When I am annoyed or irritated*:*						
I am able to express my feelings	☐	☐	☐	☐	☐	I keep my feelings to myself
When I work or play:						
I don't feel very competitive	☐	☐	☐	☐	☐	I feel I must always win
When I am eating,walking or driving:						
I feel I can take my time	☐	☐	☐	☐	☐	I feel I must hurry
Most days:						I feel I am under considerable
I feel calm and relaxed	☐	☐	☐	☐	☐	nervous strain
	1	**2**	**3**	**4**	**5**	
At the end of a day:						I feel mentally and physically
I still feel vigorous and enthusiastic	☐	☐	☐	☐	☐	exhausted
Activities I formerly enjoyed:						
Still please and interest me	☐	☐	☐	☐	☐	no longer give pleasure
I feel that my energy levels:						
Are as high as ever	☐	☐	☐	☐	☐	Are much lower than before
When I wake in the morning:						
I feel rested and refreshed	☐	☐	☐	☐	☐	I feel tired and weary
I feel that my hobbies and interests:						
Are still interesting and enjoyable	☐	☐	☐	☐	☐	Are no longer of interest
	1	**2**	**3**	**4**	**5**	
Outside of work hours:						
I seldom give work a thought	☐	☐	☐	☐	☐	I constantly think about work
At work and home:						I feel that I get little or no
I feel that I get plenty of support	☐	☐	☐	☐	☐	support
I feel that my life is:						
Under my control	☐	☐	☐	☐	☐	Largely outside my control
When I have a problem I feel:						
I have good sources of help	☐	☐	☐	☐	☐	I have no one to rely on
I feel I am:						I feel largely non-productive
Productive and effective	☐	☐	☐	☐	☐	and ineffective

DIET QUESTIONS

We know questions on diet are difficult however try to be accurate. We need an overview of the *general trends* in your diet. The information will be used to advise you if you have any abnormal test results.

On each line tick the box with the nearest correct answer ☑

I consider my weight to be:					
about right or underweight	☐	moderately overweight	☐	very overweight	☐
My breakfast is usually:					
a substantial or large meal	☐	a moderate to small meal	☐	a cup of coffee, piece of toast or less	☐
My evening meal is:					
small or light	☐	a moderate size	☐	the largest meal of the day	☐
I eat or snack between meals:					
once or less per day	☐	1 to 2 times per day	☐	3 or more times per day	☐
I eat take-away or dine out:					
occasionally	☐	few (4-6) times per month	☐	frequently (>7) or most days a month	☐
I eat to relax:					
always	☐	usually	☐	rarely	☐
I eat breakfast cereals:					
most days	☐	1 to 3 times per week	☐	never or occasionally	☐
I eat rice, beans or pasta:					
most days	☐	1 to 3 times per week	☐	never or occasionally	☐
I eat fresh or dried fruit:					
2 + pieces or serves daily	☐	1 piece or serve most days	☐	never or occasionally	☐
I eat vegetables or salad					
most days	☐	1 to 3 times per week	☐	never or occasionally	☐
I eat bread (including sandwiches and toast)					
6 or more slices per day	☐	3 to 5 slices per day	☐	2 or less slices per day	☐
I eat red meat (including ham and pork):					
never or occasionally	☐	1 to 3 times per week	☐	4+ i.e. most days	☐
I eat butter or margarine:					
sparingly or not at all	☐	moderately	☐	heavily	☐

DIET CONTINUED

On each line tick the box with the nearest correct answer ☑

I use mayonnaise or salad dressings:					
sparingly or not at all	☐	moderately	☐	frequently	☐
I use cream					
sparingly or not at all	☐	moderately	☐	frequently	☐
I eat deli meats or sausages:					
sparingly or not at all	☐	1 to 3 times per week	☐	most days	☐
I eat block or processed cheese:					
sparingly or not at all	☐	1 to 3 times per week	☐	most days	☐
I eat eggs:					
sparingly or not at all	☐	1 to 3 times per week	☐	most days	☐
When I eat eggs I usually have:					
1 egg	☐	2 eggs	☐	3 or more eggs	☐
I eat chocolates, chocolate bars or similar rich snacks:					
sparingly or not at all	☐	1 to 3 times per week	☐	most days	☐
I eat fried food or take-away:					
occasionally	☐	1 to 3 times per week	☐	most days	☐
I eat biscuits, cakes or pastries:					
1 or 2 pieces a week	☐	3 to 6 pieces per week	☐	2 or more pieces most days	☐
I drink or use whole milk (1 cup or glass):					
less than 1 per day	☐	1 to 2 times per day	☐	3 or more times per day	☐
I remove fat from my meat:					
always or don't eat meat	☐	most times	☐	seldom or never	☐
I eat ice cream:					
occasionally	☐	1 to 3 times per week	☐	most days	☐
I select low fat products (dairy products etc):					
all the time	☐	often	☐	seldom or never	☐
I add salt to my meals:					
rarely or never	☐	often	☐	most meals	☐

DIET CONTINUED

On each line tick the box with the nearest correct answer ☑

I eat deserts, sweets or ice cream:					
occasionally	☐	1 to 3 times per week	☐	most days	☐
I eat lollies or chocolates:					
occasionally	☐	1 to 3 times per week	☐	most days	☐
When I eat lollies or chocolates I have:					
1 or 2 pieces (or squares)	☐	3 to six pieces	☐	a lot	☐
I eat honey or jam (sweet spreads):					
occasionally	☐	1 to 3 times per week	☐	most days	☐
I eat sweet pastries, biscuits or cakes:					
occasionally	☐	1 to 3 times per week	☐	most days	☐
I drink sweetened soft drinks, colas or fruit juices:					
occasionally	☐	1 to 3 times per week	☐	most days	☐
On the days when I drink sweetened drinks I have:					
only 1 can or drink	☐	2 to 3 cans or drinks	☐	4 or more cans or drinks	☐
I drink a hot drink:					
3 or less times a day	☐	4 to 7 times per day	☐	8 or more times per day	☐
When I have a hot drink I use:					
no sugar	☐	1 to 2 teaspoons of sugar	☐	3 or more tsps of sugar	☐
I consciously choose low calorie foods:					
all the time	☐	mostly	☐	rarely	☐
How many <u>caffeine</u> containing drinks you have in an average day? (Please insert the number)		Cups of coffee		Cups	
		Cups of Tea		Cups	
		Cans/glasses of Cola		Cans/Glasses	
I have a glass of water:					
occasionally	☐	1 to 3 glasses daily	☐	>3 glasses daily	☐

The Stress Test

<u>Please bring along a set of clothes and sports (walking) shoes</u>, in which to do the treadmill test (ie exercising gear) as in all likelihood you will sweat a little. Shower facilities are available for use following your assessment. A towel can be provided.

The law supports your right to know what to expect in any medical procedure and any associated risks. Your doctor has referred you for a maximal Exercise ECG otherwise commonly called a "Stress Test". This involves a preliminary resting Electrocardiograph (ECG) followed by walking exercise on a treadmill with continuous ECG, heart rate and blood pressure monitoring.

How Is It Done?

The treadmill is essentially a small moving-footway. When you are ready and standing on the treadmill it will be started slowly then increased to a speed of 2.8 km / hr (a slow walking pace) and an inclination of 10%. As the test proceeds the inclination is increased 2% every 3 minutes and the speed increases to 4km/hr, 5.5 km/hr then 6.8 km/hr (power walking). The aim is to increase one's heart rate to the maximum possible for that individual, whilst monitoring all cardiovascular changes and maintaining patient safety. The test is always stopped if the patient so requests.

A person of poor fitness will manage only 6 or 7 mins, average 9 to 10 minutes and very good over 12 mins (categories of fitness vary with age) while a super-fit person may exercise for 15 to 18 minutes. You should exercise until you feel compelled to stop, usually due to leg fatigue, general fatigue, shortness of breath or chest pain. We may stop you earlier if we feel there is a problem with your ECG, heart rhythm or blood pressure.

At the end of this exercise phase the treadmill is lowered quickly and stopped so a good quality ECG can be obtained. You will then be seated for a further recovery/observation period of 4 to 6 minutes at rest.

How Will I Feel?

Your legs may feel unsteady momentarily on stepping off the treadmill. A very small number of people briefly feel faint or nauseated. You will probably sweat, perhaps profusely, as you would after any vigorous exercise. You may have joint or muscle soreness depending on any predisposing problem just as you would expect from any physical activity.

Are There Any Risks?

Stresses, strains and direct risks are associated with all procedures and even with life's daily activities. As with any moving equipment you might trip or stumble and sustain minor injury or abrasion, though the equipment is built for maximum convenience and safety. This is most likely to occur if you act independently by jumping off while the treadmill belt is still moving. Please follow instructions and keep us informed about how you feel and what you would like to do. Always inform staff of any symptoms which you are beginning to experience esp. chest pain/tightness/discomfort (however minor); arm, neck or jaw ache; breathlessness; light-headed/dizziness.Very occasionally an excessive rise in blood pressure or a potentially serious irregularity of heart rhythm may occur and we will stop the test procedure; in all cases in our laboratory the problem has promptly resolved.

Serious complications are extremely rare (2 or 3 per 10,000 tests). There is a theoretical risk of cardiac arrest or myocardial infarct (heart attack) as in any predisposed person who indulges in strenuous exercise. If we think you are likely to be at high risk esp if your Resting ECG indicates recent heart damage we may decline to test you.

Who Conducts the Test?
The technicians are fully qualified nursing sisters trained in this particular procedure and with cardiopulmonary resuscitation training. Emergency equipment is immediately at hand. A medical practitioner is present in the room and a medical resuscitation team is always available in the adjacent hospital building (Accident & Emergency Dept).

We May Decline to Test You
Although stress testing is a very low risk procedure, if we suspect you may be at risk (before or after the preliminary ECG) we will advise you to seek further cardiac advice before having a stress test or arrange stress testing on another occasion under the supervision of a consultant specialist cardiologist. This is extremely rare.

Having read this information, if you wish to proceed with stress testing you will be asked to **sign** the following consent form prior to commencing the test. If you have any further queries, please do not hesitate to contact Fox Valley Medical Centre on 02 9487 9700 or email us.

Please bring along a change of clothes and sports shoes, in which to do the treadmill test. Shower facilities are available for use following your assessment. A towel can be provided.

Please don't forget to bring these completed 13 pages with you. Regards.

CONSENT TO UNDERGO EXECUTIVE HEALTH CHECK

(Print Name)

I,_____, having read all the above information, agree to undergo a supervised Exercise ECG ("Stress Test") on a motorised treadmill. I understand all the risks, however small, it entails.

Signed _____ dated / / 20

I (person named above) also understand that the 2 hour Health Assessment is in addition (<u>not</u> a substitution) to seeing a regular physician (eg GP, Family Care Practitioner) who remains the overall coordinator/manager of my health care.

I agree to providing my regular physician/GP with all these results as soon as possible or practical, for further discussion and ongoing management, rechecking and monitoring especially any abnormal results (eg blood tests marked as "high" or "low").

I agree that although the Assessment is comprehensive, it may not detect all conditions/diseases/illnesses especially those in their early stages; which is why ongoing assessment/management with a GP is vital, as well as providing copies of all results to the same GP/medical practice for maintaining continuity of care.

Signed _____ dated / / 20

☐ I DO NOT wish for my email address or mobile phone number to be used for the purpose of recall reminder for the Executive Health Check (one email or SMS in 12 months) or for other marketing purposes by Sydney Adventist Hospital Ltd. Further info at www.sah.org.au/Privacy