Cleveland Clinic
Canada

Executive Health Questionnaire (Year 1)

Brookfield Place, Suite 3000
181 Bay Street
Toronto, Ontario M5J 2T3
Tel: 416.507.6600 Fax: 416.507.6610

PLEASE RETURN YOUR MEDICAL QUESTIONNAIRE AS SOON AS POSSIBLE SO THAT IT MAY BE REVIEWED PRIOR TO YOUR EXECUTIVE HEALTH ASSESSMENT. PLEASE FAX YOUR FORM TO 416-507-6610 OR EMAIL TO CANADAFORMS@CCF.ORG - THANK YOU.

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Executive Health Questionnaire

PLEASE FAX THIS COMPLETED REPORT
TO THE CONFIDENTIAL FAX MACHINE 416 507-6610

☐☐☐☐☐☐☐☐

Last Name	First Name	Middle Name	OHIP #	Version code & Expiry Date
Home Address			☐ Home or ☐ Cell Phone (include area code)	
City	Province	Postal Code	Business Phone	Ext.
Email			Preferred Contact # ☐ Home/Cell ☐ Business	Confidential voicemail? ☐ Yes ☐ No
Birth Date (MM, DD, YYYY)		Age		
Employer		Occupation/Title		
Emergency Contact		Relationship	Emergency Contact Number:	

Marital Status
☐ Married/Common-Law ☐ Widowed
☐ Divorced/Separated ☐ Never Married

Do you have Children? ☐ Yes ☐ No If yes, how many: _____

☐ Male ☐ Female -BDate	☐ Male ☐ Female - BDate
☐ Male ☐ Female -BDate	☐ Male ☐ Female - BDate
☐ Male ☐ Female -BDate	☐ Male ☐ Female - BDate

Physicians and Allied Health Professionals (Please list other specialty physicians you may have.)

Name	Specialty	Phone	Fax
	Family Doctor		

Allergies

Medications, Foods, Substances or Allergens	Type of reaction
1.	
2.	
3.	
4.	

Medications ** PLEASE BRING ALL YOUR MEDICATIONS TO YOUR APPOINTMENT**

Name	Dosage	Frequency	Name	Dosage	Frequency
1.*Example: ASA*	80mg.	1 tablet daily	5.		
2.			6.		
3.			7.		
4.			8.		

Do you take supplements? ☐ Yes ☐ No (Please list all including dosage and frequency.)

Name	Dosage	Frequency

Please attach list of additional supplements to your questionnaire if required.

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MEDICAL HISTORY

Current Health Problems (medical diagnosis you are CURRENTLY being treated for)	**Date of Onset**
1.	
2.	
3.	
4.	

Past Medical History (medical diagnosis you have been treated for in the past)	**Date**
1.	
2.	
3.	
4.	

Surgical History and Injuries	**Date**
1.	
2.	
3.	
4.	

Family History (Please indicate which of your blood relatives have or had the medical conditions noted and the age at death if known) (Please circle brother or sister as applicable)

CONDITION	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sister SIS/BRO	Sister SIS/BRO	Sister SIS/BRO	Sister SIS/BRO
Alive or Deceased										
Age										
Cancer (indicate type)										
Heart Disease (ie heart attack)										
Elevated Blood Pressure										
Diabetes										
Elevated Cholesterol										
Stroke										
Lung Disease										
Thyroid Disease										
Osteoporosis										
Dementia										
Other										

Details

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Past Investigations/Immunizations (please bring any results/records that you have)			
	Date (MM/DD/YYYY)		**Date (MM/DD/YYYY)**
☐ Mammogram		☐ Hepatitis A	
☐ Colonoscopy		☐ Hepatitis B	
☐Pap Smear		☐ Twinrix (Hep A and B)	
☐ Tetanus		☐ Zostavax	
☐ Influenza		☐ Pneumovax	

Health Behaviors

SMOKING

1. Do you currently smoke? ☐ YES (Go to question 4)
   ☐ NO (Go to next question)

2. Have you smoked in the past ☐ YES (Go to next question)
   ☐ NO (Go to question 5)

3. When did you start smoking? _____
   When did you quit smoking? _____
   On average, how many cigarettes a day did you smoke? _____

4. When did you start smoking?_____
   On average, how many cigarettes do you smoke daily?_____
   Have you tried to quit before? ☐ YES
   ☐ NO

ALCOHOL

5. Do you currently drink alcohol ☐ YES (Go to next question)
   ☐ NO (Go to question 7)

6. In a typical week, on how many days to you drink alcohol? _____
   In a typical week, how many standard servings would you have of the following?
   Wine_____ Beer_____ Mixed Drinks/Spirits_____

OTHER DRUGS

7. Do you currently use any recreational drugs? ☐ YES (Go to next question)
   ☐ NO (Go to next section)

8. In a typical week, on how many days do you use recreational drugs? _____
   If less than weekly, how many times a month do you use recreational drugs? _____
   If less than monthly, how many times a year do you use recreational drugs? _____
   What type(s) of recreational drugs do you use? _____

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Executive Health Psychology Questionnaire

Last Name	First Name and Initial

How satisfied are you with the following areas in your life? Check after the number that corresponds to your satisfaction level.

1= Not Satisfied **10= Very Satisfied**

	1	2	3	4	5	6	7	8	9	10
Work Life										
Family Life										
Physical Health/Fitness										
Intimate/Sexual Life										
Level of Friendships/Social Life										
Recreational activities/hobbies/interests										
Mood										
Ability to Cope with Stress/Anxiety										
Ability to Relax										
Ability to Balance Home/Work										
Quality of Sleep										

Please describe any recent LIFE STRESSORS (e.g., health, relationships, financial, work)?

_____
_____
_____
_____

Please indicate any specific concern or HEALTH & WELLNESS <u>GOAL(S)</u> you would like to discuss with our Psychology staff:

- ☐ Stress management principles
- ☐ Family relationships
- ☐ Mood/Anxiety
- ☐ Healthier Lifestyle Choices (i.e., weight loss management)
- ☐ Work-Life Balance
- ☐ Preventative Health & Wellness
- ☐ Alcohol Consumption
- ☐ Sleep Quality

Other (please describe):

_____
_____
_____

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Executive Health Activity Questionnaire

In a typical week, how many times do you do the following kinds of activity for more than 15 minutes at a time?

	Times per week (if more than 7, indicate number)							
Strenuous exercise (hearts beat rapidly) (Running/Jogging, Hockey, Soccer, Squash, Basketball, Cross country skiing, Vigorous swimming, Vigorous long distance cycling, etc.)	1	2	3	4	5	6	7	Other ____
Moderate exercise (not exhausting) (Fast walking, Tennis, Baseball, Easy cycling, Volleyball, Badminton, Downhill skiing, Easy swimming, etc)	1	2	3	4	5	6	7	Other ____
Mild exercise (minimal effort) (Easy walking, Golf, Yoga, Archery, Bowling)	1	2	3	4	5	6	7	Other ____
Sedentary activities (sitting for more than 2 hours in a row)	1	2	3	4	5	6	7	Other ___
Weekly total								_ _____

Executive Health Eating Habits Questionnaire

In an average week, how often do you…	Please indicate the number of days per week:							
Eat breakfast?	0	1	2	3	4	5	6	7
Eat lunch?	0	1	2	3	4	5	6	7
Go longer than 4 hours without having a meal or snack? (excluding overnight)	0	1	2	3	4	5	6	7
Eat the following meals out at a restaurant or take-out?								
a. Breakfast	0	1	2	3	4	5	6	7
b. Lunch	0	1	2	3	4	5	6	7
c. Dinner	0	1	2	3	4	5	6	7
How would you rate your cooking and meal preparation skills (Note scale: 0 = I do not cook; 3= Adequate, 4 = Good; 7=Excellent)	0	1	2	3	4	5	6	7
Do you feel you have any problematic eating behaviors?	Yes				No			
How willing are you to make changes in your eating habits to be healthier? (Note scale: 0 = Not at all or Not applicable, 3= Somewhat, 7 = Very)	0	1	2	3	4	5	6	7