ANNUAL PHYSICAL

Patient Name: _____Date_____

General

Energy Level: Low Medium High _____

Weight change in the last 3 to 6 months: Lost No change Gain

_____

Sleep: Good Poor

HEENT

Eyes: Glasses/Contacts Glaucoma Cataract Other

Last eye exam: _____

Ears: Hearing loss Constant ringing Other

Sinus symptoms _____

History of environmental allergies _____

Pulmonary

Asthma Emphysema Cough Shortness of breath

Tuberculosis Exposure Pneumonia _____

Cardiovascular

High Blood Pressure Heart Murmur Palpitations Heart Attack

High Cholesterol Rheumatic Fever Chest Pain

Exercise What Type _____ How Often _____

Gastrointestional

Frequent Heartburn or Indigestion _____History of ulcers _____

Hepatitis/Jaundice Gallstone _____ Frequent bouts of Diarrhea

Constipation Rectal Bleeding

Date of last Colonoscopy _____

Genitourinary

FEMALE: Irregular Menses Abnormal Vaginal Bleeding Abnormal Discharge

Last menstrual period _____ Approx age at Menopause _____

Hysterectomy? Yes or No

Hormones after Menopause? _____

Date of Last Pap Smear? _____ Any Abnormal Paps? _____

Date of Last Mammogram _____Any Abnormal Mammograms? _____

Do you perform monthly Breast Self-Exams? _____

Any history of Frequent Urinary Bladder Infections _____

Kidney Stones? _____ Any Incontinence? _____

MALES: Night-time Urination Impaired Urine Flow Cancer

Prostate Infection Swelling in Scrotum Abnormal Penile Discharge

Impotency Kidney Stone _____

Musculoskeletal

Joint Pain History of Arthritis Gout Back Problems

Neurological

Migraines Stroke Seizures Weakness Black-outs Dizziness

HEME

Blood Transfusions Tattoos

Patient Name:_____

Endocrine
( ) Diabetes ( ) Thyroid Problems Last Bone Density _____
Skin
( ) Cancer ( ) Rash ( ) Changing Moles ( ) Psoriasis ( ) Other_____

Immunizations: **Last Tetanus _____ Pneumonia Vaccine_____**

Do you have a history of any type of Cancer? _____

What is the purpose of your visit to the Doctor today? (physical, problems/concerns)

_____

_____

_____

Previous Medical History (list all surgerys, hospitalizations, significant illnesses)

_____

_____

_____

Habits
Smoking: **( ) Never ( ) Current ( ) Previously ( ) Smokeless Tobacco**
Number of Years: _____ Packs Per Day: _____
Alcohol: ( ) Never **( ) Current ( ) Previously Per day/week _____**
Illicit Drug Use: ( ) Past _____ ( ) Present _____

Medications Currently Taking: _____

_____

_____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed
Number of Children: _____
Occupation: _____
Religion: _____

Family History: _____

_____

_____

Mother: ( ) Living ( ) Deceased Age _____
Father: ( ) Living ( ) Deceased Age _____
Siblings: _____

Significant Family Health Problems:
( ) Heart Attack _____
( ) Diabetes _____
( ) High Blood Pressure _____
( ) Cancer _____
( ) Other _____