PHYSICAL EXAM FORM

Patient Name ____ DOB______________________________

1) Please list your 3 main concerns in order of importance: (Please note you may need to make additional appointments for multiple concerns)
   a) ____
   b) ____
   c) ____

2) Past medical history: (check all that apply)
   Anxiety ___ Cancer-Type ______________ Headaches ___ HIV/AIDS ___
   Arthritis ___ Diabetes ___ Heart disease ___ Osteoporosis __
   Asthma ___ Depression ___ High Blood Pressure ___Stroke/TIA ___
   Blood disorder ___ Gallbladder/liver disease ___ High Cholesterol ___ Thyroid disorder ___
   Other ______________________

3) Please list any past surgeries:
   _______________________________ ____
   _______________________________ ____

4) Please list any current medications (prescription or over the counter), vitamins, supplements, etc: (please state doses if known)
   ___________________________________ ____
   ___________________________________ ____
   ___________________________________ ____

5) Please list any allergies to medications and reactions if known:
   ___________________________________ ________________________________

6) Please list any other health care providers involved in your care: (include phone number/address if known)
   __________________________________ ___________________________________

7) Family medical history-conditions present in Mother, Father or Siblings: (check all that apply)
   Anxiety ___ Cancer-Type _____________ Headaches ___ HIV/AIDS ___
   Arthritis ___ Diabetes ___ Heart disease ___ Osteoporosis ___
   Asthma ___ Depression ___ High Blood Pressure ___Stroke/TIA ___
   Blood Disorder ___ Gallbladder/liver disease ___ High Cholesterol ___ Thyroid disorder ___
   Other __________________

8) Social History: (please check appropriate box) and, if applicable (number of children)
   Married ___ Divorced ___ Single ___ Widowed___ Significant other ___ Number/children:_____
   Education: grade school __ high school __ college __ graduate degree __
   Exercise: What type: ____________________How often: >5x/week ___ 3-5 x/week ___ 1-3x/week ___ none ___
   Diet/Nutrition: ____
   Work History: and Job Title/Description: ____
   Employed: full time ___ part time ___ unemployed ___ retired ___
   Smoking: (cigarettes or cigars) never ___ current: how much? ___ former: when did you quit? ______
   Alcohol: never___ how often____________ how much___________ history of abuse ___
   Illicit drug use: marijuana ___ cocaine/crack __heroin ___ ecstasy ___ other _____________

9) Are you or have you ever been a victim of any type of violence/abuse? ______________________

10) Do we have a copy of your completed Advanced Directives? Yes ___ No ___ Unsure ____

Review of Systems DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING ISSUES:

CONSTITUTIONAL:

Appetite change _____
Weight gain _____
Weight loss _____
Fever _____
Chills _____
Sweating _____
Tired _____
Weakness ______
Falls _____
Other ________

EYES:

Change in vision _____
Double vision _____
Loss of vision _____
Pain ______
Burning _______
Itching ______
Discharge _____
Redness _____
Other _____

EARS, NOSE, MOUTH AND THROAT:

Facial pain ______
Jaw pain _____
Ear pain ______
Hearing loss _____
Ringing in ears ______
Nasal congestion _____
Runny nose _____
Nasal drainage ______
Dental problems _______
Mouth sores ______
Hoarseness_____
Lump in throat ______
Sore throat ______
Difficulty swallowing ____
Other _______

CARDIOVASCULAR:

Chest pain ____
Irregular heart __
Racing heart ____
SOB with exertion _____
SOB at night _______
Other ______

RESPIRATORY:

Cough ____
Phlegm _____
Difficulty breathing ___
Shortness of breath ___
SOB with exertion ______
Wheezing _____
Other _____

BREAST:

Lump ______
Skin changes ______
Nipple discharge ____
Other ______

GASTROINTESTINAL:

Nausea ______
Vomiting _____
Diarrhea _____
Constipation _______
Change in stool color ____
Bright red blood on paper____
Bloody stools _____
Black stools _____
Abdominal pain ____
Pelvic pain ____
Other ____

GENITOURINARY:

Incontinence _____
Problems urinating _____
Frequent urination _____
Urgency _____
Pain with urination _____
Decreased urination ____
Incomplete emptying of bladder_____
Blood in urine ____
Vaginal discharge ____
Abnormal bleeding ____
Heavy periods ____
Painful periods ____
Irregular periods ____
Missed period ____
Pelvic pain ____
Sexual dysfunction ____
Pain with intercourse ____
Sores ____
Other _____

MUSCULOSKELETAL:

Muscles aches _____
Back pain ____
Joint pain ____
Neck pain ____
Neck stiffness ____
Other _____

EXTREMITIES:

Pain in upper extremities ____
Pain in lower extremities _____
Pain with walking _____
Leg swelling ____
Calf tenderness ____
Ankle swelling _____
Nail changes _____
Other ___

INTEGUMENTARY:

Skin injury ____
Burn _____
Hives _____
Itching ______
Rash _____
Moles ______
Abnormal skin color ______
Sores ______
Other ______

HEMATOLOGIC/LYMPHATIC:

Bruises _____
Swollen glands ______
Frequent nose bleeds ____
Bleeding gums w/brushing ____
Heavy menstrual periods _____
Other ______

ENDOCRINE:

Heat/cold intolerance ______
Increased thirst _____
Dissatisfaction with weight _____
Hair loss ______
Other _____

NEUROLOGICAL:

Headache ____
Head injury _____
Lightheaded _____
Dizziness _____
Blacking out _____
Weakness _____
Weakness in specific limb _____
Difficulty walking _____
Numbness _____
Tingling _____
Tremors _____
Restless legs______
Other ______

PSYCHIATRIC:

Difficulty sleeping _____
Trouble concentrating ___
Feeling depressed ____
Feeling anxious _____
Feels safe in home ____
Confusion ____
Hearing voices ____
Paranoid thoughts ____
Mood changes ____
Suicidal thoughts ____
Other ______

HEALTH MAINTENANCE:

Last Td/Tdap ______________
Last Colonoscopy _____________
Last Bone Mineral Density _______
Last Fasting Labs ______________
Last Eye Exam ________________

IF YOU ARE HERE FOR A YEARLY WELL WOMAN EXAM/ROUTINE PAP SMEAR/PELVIC EXAM, PLEASE ALSO FILL OUT THE NEXT PAGE.

WELL-WOMAN/PAP SMEAR/PELVIC EXAM SECTION

(Please note, if you have concerns that go beyond your routine maintenance exam, additional appointments may be necessary to fully address those concerns.)

Last Pap Test ____________________

History of abnormal pap? _____ yes ______no

Have you had a mammogram? ____ yes ______ no Date of last one: _____________________

PREGNANCY HISTORY:
Total number of times pregnant ________________

Number of living children _____________________

Number of stillbirths _________________________

Number of miscarriages ________________________

Number of inducted abortions ___________________

Type of deliveries: ______Vaginal _______ Caesarean

Have you ever had gestational diabetes: _____ yes ______no

Have you ever had an ectopic (tubal) pregnancy? _____ yes ______no

Do you plan any (more) pregnancies? ______yes, when? _________ ________no ________undecided

MENSTRUAL HISTORY:
First day of last normal period ___/_____/______

How often do you get your period? Every _____ days

How many days do you bleed? _______________

Is your bleeding: ______ Light ________Medium _______Heavy

Unusual or missed periods in past year _____yes ______no

Severe menstrual cramps ______yes ________no

Premenstrual discomfort _______yes ________no

Do you think you might be pregnant now? _______yes _______no

Are you currently sexually active? ________yes _______no
Any problems or concerns? _____ yes ______no
Is your partner _______ male ______ female

Are you currently using birth control? ___________yes ___________no
If yes, which method _________________________________
Problems, if any _____________________________________

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