**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)
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any past surgeries:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any allergies to medications and reactions if known:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Family medical history-**(Please list which family member has dealt with each issue**):

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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 \_\_\_\_\_\_\_\_\_\_\_\_

1. Are you or have you ever been a victim of any type of violence/abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. 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:** **EYES:** **EARS, NOSE, MOUTH AND THROAT:** **CARDIOVASCULAR:**

Appetite change \_\_\_\_\_ Change in vision \_\_\_\_\_ Facial pain \_\_\_\_\_\_ Hoarseness\_\_\_\_\_ Chest pain \_\_\_\_

Weight gain \_\_\_\_\_ Double vision \_\_\_\_\_ Jaw pain \_\_\_\_\_ Lump in throat \_\_\_\_\_\_ Irregular heart \_\_

Weight loss \_\_\_\_\_ Loss of vision \_\_\_\_\_ Ear pain \_\_\_\_\_\_ Sore throat \_\_\_\_\_\_ Racing heart \_\_\_\_

Fever \_\_\_\_\_ Pain \_\_\_\_\_\_ Hearing loss \_\_\_\_\_ Difficulty swallowing \_\_\_\_ SOB with exertion \_\_\_\_\_

Chills \_\_\_\_\_ Burning \_\_\_\_\_\_\_ Ringing in ears \_\_\_\_\_\_ Other \_\_\_\_\_\_\_ SOB at night \_\_\_\_\_\_\_

Sweating \_\_\_\_\_ Itching \_\_\_\_\_\_ Nasal congestion \_\_\_\_\_ Other \_\_\_\_\_\_

Tired \_\_\_\_\_ Discharge \_\_\_\_\_ Runny nose \_\_\_\_\_

Weakness \_\_\_\_\_\_ Redness \_\_\_\_\_ Nasal drainage \_\_\_\_\_\_

Falls \_\_\_\_\_ Other \_\_\_\_\_ Dental problems \_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_ Mouth sores \_\_\_\_\_\_

**RESPIRATORY:** **BREAST:** **GASTROINTESTINAL:** **GENITOURINARY:**

Cough \_\_\_\_ Lump \_\_\_\_\_\_ Nausea \_\_\_\_\_\_ Abdominal pain \_\_\_\_ Incontinence \_\_\_\_\_

Phlegm \_\_\_\_\_ Skin changes \_\_\_\_\_\_ Vomiting \_\_\_\_\_ Pelvic pain \_\_\_\_ Problems urinating \_\_\_\_\_

Difficulty breathing \_\_\_ Nipple discharge \_\_\_\_ Diarrhea \_\_\_\_\_ Other \_\_\_\_ Frequent urination \_\_\_\_\_

Shortness of breath \_\_\_Other \_\_\_\_\_\_ Constipation \_\_\_\_\_\_\_ Urgency \_\_\_\_\_

SOB with exertion \_\_\_\_\_\_ Change in stool color \_\_\_\_ Pain with urination \_\_\_\_\_

Wheezing \_\_\_\_\_ Bright red blood on paper\_\_\_\_ Decreased urination \_\_\_\_

Other \_\_\_\_\_ Bloody stools \_\_\_\_\_ Incomplete emptying of bladder\_\_\_\_\_ Black stools \_\_\_\_\_ Blood in urine \_\_\_\_

Vaginal discharge \_\_\_\_

**MUSCULOSKELETAL:** **EXTREMITIES:** Abnormal bleeding \_\_\_\_

Muscles aches \_\_\_\_\_ Pain in upper extremities \_\_\_\_ Heavy periods \_\_\_\_

Back pain \_\_\_\_ Pain in lower extremities \_\_\_\_\_ Painful periods \_\_\_\_

Joint pain \_\_\_\_ Pain with walking \_\_\_\_\_ Irregular periods \_\_\_\_

Neck pain \_\_\_\_ Leg swelling \_\_\_\_ Missed period \_\_\_\_

Neck stiffness \_\_\_\_ Calf tenderness \_\_\_\_ Pelvic pain \_\_\_\_

Other \_\_\_\_\_ Ankle swelling \_\_\_\_\_ Sexual dysfunction \_\_\_\_

Nail changes \_\_\_\_\_ Pain with intercourse \_\_\_\_

Other \_\_\_ Sores \_\_\_\_

Other \_\_\_\_\_

**INTEGUMENTARY:** **HEMATOLOGIC/LYMPHATIC:** **ENDOCRINE:**

Skin injury \_\_\_\_ Bruises \_\_\_\_\_ Heat/cold intolerance \_\_\_\_\_\_ **NEUROLOGICAL:**

Burn \_\_\_\_\_ Swollen glands \_\_\_\_\_\_ Increased thirst \_\_\_\_\_ Headache \_\_\_\_

Hives \_\_\_\_\_ Frequent nose bleeds \_\_\_\_ Dissatisfaction with weight \_\_\_\_\_ Head injury \_\_\_\_\_

Itching \_\_\_\_\_\_ Bleeding gums w/brushing \_\_\_\_ Hair loss \_\_\_\_\_\_ Lightheaded \_\_\_\_\_

Rash \_\_\_\_\_ Heavy menstrual periods \_\_\_\_\_ Other \_\_\_\_\_ Dizziness \_\_\_\_\_

Moles \_\_\_\_\_\_ Other \_\_\_\_\_\_ Blacking out \_\_\_\_\_

Abnormal skin color \_\_\_\_\_\_ Weakness \_\_\_\_\_

Sores \_\_\_\_\_\_ Weakness in specific limb \_\_\_\_\_

Other \_\_\_\_\_\_ Difficulty walking \_\_\_\_\_

Numbness \_\_\_\_\_

**PSYCHIATRIC:** **HEALTH MAINTENANCE:** Tingling \_\_\_\_\_

Difficulty sleeping \_\_\_\_\_ Confusion \_\_\_\_ Last Td/Tdap \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tremors \_\_\_\_\_

Trouble concentrating \_\_\_ Hearing voices \_\_\_\_ Last Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_ Restless legs\_\_\_\_\_\_

Feeling depressed \_\_\_\_ Paranoid thoughts \_\_\_\_ Last Bone Mineral Density \_\_\_\_\_\_\_ Other \_\_\_\_\_\_

Feeling anxious \_\_\_\_\_ Mood changes \_\_\_\_ Last Fasting Labs \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feels safe in home \_\_\_\_Suicidal thoughts \_\_\_\_ Last Eye Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_

**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

Last Pap Test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of abnormal pap? \_\_\_\_\_ yes \_\_\_\_\_\_no

Have you had a mammogram? \_\_\_\_ yes \_\_\_\_\_\_ no Date of last one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had colon cancer screening?

If yes, what test was done, and when and result if known:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had bone density screening?

If so, when and what was the result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

GYNECOLOGICAL 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

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 9/16/20