NEW PATIENT PHYSICAL EXAM FORM

Patient Name _____ DOB_____

Please list any other health care providers involved in your care:

_____ _____

1) Please list your main concerns in order of importance:
   a)_____
   b)_____
   c)_____

2) Past medical history: (circle all that apply)

Anxiety	Cancer-Type	Headaches	HIV/AIDS
Arthritis	Diabetes	Heart disease	Osteoporosis
Asthma	Depression	High blood pressure	Stroke/TIA
Blood clots	Incontinence (urine or feces)	High Cholesterol	Thyroid disorder
Blood disorder	Gallbladder/liver disease	GI disease	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) Family medical history-**(Please list which family member has dealt with each issue**):

Alcohol/Drug abuse_____	Headaches_____	Stroke/TIA_____
Alzheimer's_____	Heart disease_____	Thyroid disorder_____
Anxiety _____	Cancer-Type _____	Osteoporosis_____
Arthritis _____	Diabetes _____	High Cholesterol_____
Asthma _____	Depression _____	High Blood Pressure _____
Blood Clots _____	Genetic Disorders _____	Other _____
Blood Disorder _____	Gallbladder/liver disease _____	

7) Social History:

   Married ___ Divorced ___ Single ___ Widowed___ Significant other ___ Number/children:_____
   Exercise: What type: _____How often: >5x/week ___ 3-5 x/week ___ 1-3x/week ___ none ___
   Diet/Nutrition: _____
   Work History: and Job Title/Description: _____
   Hobbies: _____
   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 _____

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

9) 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:

INTEGUMENTARY

Skin Injury
Burn
Hives
Itching
Rash
Moles
Abnormal skin color
Sores
Other
Restless legs
Other:

GENITOURINARY

Incontinence
Frequent Urination
Urgency
Pain with Urination
Decreased urination
Pelvic pain
Blood in urine
Vaginal discharge
Abnormal bleeding
Incomplete emptying
Other:

MUSCULOSKELETAL

Muscle aches
Back pain
Joint pain
Neck pain
Other
Nail changes
Pain in arms/legs
Pain with walking
Leg swelling
Calf tenderness
Ankle swelling
Other:

EARS, NOSE, MOUTH AND THROAT

Facial 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:

CONSTITUTIONAL

Appetite change
Weight gain
Weight loss
Fever
Chills
Sweating
Tired
Weakness
Other:

GASTROINTESTINAL

Nausea
Abdominal pain
Vomiting
Diarrhea
Other
Constipation
Change in stool color
Bloody stools
Black stools
Other:

NEUROLOGICAL

Headache
Lightheaded
Dizziness
Blacking out
Weakness
Difficulty walking
Numbness
Tingling
Tremors
Other:

PSYCHIATRIC

Difficulty sleeping
Trouble concentrating
Feeling depressed
Feeling anxious
Feels safe at home
Suicidal thoughts
Other:

EYES

Change in vision
Pain
Burning
Itching
Redness
Other:

BREAST

Lump
Skin changes
Nipple discharge
Pain
Other:

HEMATOLOGIC/LYMPHATIC

Bruises
Swollen glands
Frequent nosebleeds
Bleeding gums w/brushing
Heavy menstrual periods
Other:

CARDIOVASCULAR

Chest pain
Irregular heart
Racing heart
SOB with exertion
Other:

RESPIRATORY

Cough
Difficulty breathing
Shortness of breath
Wheezing
Other:

ENDOCRINE

Heat/cold intolerance
Increased thirst
Dissatisfaction with weight
Hair loss
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 SECTION

Last Pap Test _____History of abnormal pap? _____ yes _____no If yes, when_____

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

Have you had colon cancer screening? ____yes _____no
If yes, what test was done, when and result:_____

Have you had bone density screening?_____yes _____no
If yes, when and what was the result:_____

Last Cholesterol and Blood Sugar Test:_____

PREGNANCY HISTORY:

History of infertility: Y/N Total number of times pregnant ____
Number of live births _____ Number of miscarriages _____ Number of inducted abortions _____
Type of deliveries: Vaginal_____ Caesarean _____

Have you ever had any of the following issues during pregnancy: (circle)
Gestational diabetes Preeclampsia Fetal growth restriction
Preterm delivery Placental Abruption

GYNECOLOGICAL HISTORY: (please circle one)

Current menstrual status

- Premenopause (before menopause, having regular periods)
- Perimenopause/menopause transition (changes in periods, but have not gone 12 months in a row without a period)
- Postmenopause (after menopause)
  Was your menopause:
  - Spontaneous (natural)
  - Surgical (removed both ovaries)
  - Due to chemotherapy or radiation therapy: reason for therapy: _____

Age at first menstrual period:_____

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? Y/N Severe menstrual cramps? Y/N Premenstrual discomfort? Y/N

Do you think you have a problem with your period? Y/N
If yes, explain:_____

SEXUAL HISTORY

Are you currently sexually active? _____yes _____no
Is your partner _____ male _____ female

Any problems or concerns? _____ yes _____no

Are you currently using birth control? _____yes _____no
If yes, which method _____

Please indicate how bothered you are now and in the past few weeks by any of the following:

	Not at all	A little bit	Quite a bit	Extremely
I have hot flashes	☐	☐	☐	☐
I have night sweats	☐	☐	☐	☐
I have difficulty getting to sleep	☐	☐	☐	☐
I have difficulty staying asleep	☐	☐	☐	☐
I get heart palpitations or a sensation of butterflies in my chest or stomach	☐	☐	☐	☐
I feel like my skin is crawling or itching	☐	☐	☐	☐
I feel more tired than ususal	☐	☐	☐	☐
I have difficulty concentrating	☐	☐	☐	☐
My memory is poor	☐	☐	☐	☐
I am more irritable than usual	☐	☐	☐	☐
I feel more anxious than usual	☐	☐	☐	☐
I have more depressed moods	☐	☐	☐	☐
I am having mood swings	☐	☐	☐	☐
I have crying spells	☐	☐	☐	☐
I have headaches	☐	☐	☐	☐
I need to urinate more often than usual	☐	☐	☐	☐
I leak urine	☐	☐	☐	☐
I have pain or burning when urinating	☐	☐	☐	☐
I have bladder infections	☐	☐	☐	☐
I have uncontrolled loss of stool or gas	☐	☐	☐	☐
My vagina is dry	☐	☐	☐	☐
I have vaginal itching	☐	☐	☐	☐
I have an abnormal vaginal discharge	☐	☐	☐	☐
I have vaginal infections	☐	☐	☐	☐
I have pain during intercourse	☐	☐	☐	☐
I have bleeding after intercourse	☐	☐	☐	☐
I lack desire or interest in sexual activity	☐	☐	☐	☐
I have difficulty achieving orgasm	☐	☐	☐	☐
My stomach feels like its bloated or I've gained weight	☐	☐	☐	☐
I have breast tenderness	☐	☐	☐	☐
I have joint pains	☐	☐	☐	☐