NAME:_____ **DATE:**_____

Please complete to the best of your ability prior to your physical exam.

Do you any concerns or problems you wish to be addressed today? Please list.

_____

_____

_____

_____

_____

	Yes	No	Comments
CONSTITUTIONAL SYMPTOMS	Yes	No	
Do you feel in good general health lately?	□	□	
Any recent weight change?	□	□	
Fever?	□	□	
Headaches?	□	□	
EYES	Yes	No	
Do you have any eye disease or injury?	□	□	
Wear glasses/contact lenses?	□	□	
Blurred or double vision?	□	□	
EARS/NOSE/MOUTH /THROAT	Yes	No	
Do you have any hearing loss or ringing?	□	□	
Earaches or drainage?	□	□	
Chronic sinus problems or rhinitis?	□	□	
Nosebleeds?	□	□	
Mouth sores?	□	□	
Bleeding gums?	□	□	
Bad breath or taste?	□	□	
Sore throat or voice change?	□	□	
Swollen glands in neck?	□	□	
CARDIOVASCULAR	Yes	No	
Do you have heart trouble?	□	□	
Chest pain or angina?	□	□	
Palpitations?	□	□	

	Yes	No	Comments
Shortness of breath with walking or lying flat?	□	□	
RESPIRATORY	Yes	No	
Do you have chronic or frequent coughs?	□	□	
Spitting up blood?	□	□	
Shortness of breath?	□	□	
Asthma or wheezing?	□	□	
GASTROINTESTINAL	Yes	No	
Do you have loss of appetite?	□	□	
Change of bowel movements?	□	□	
Nausea or vomiting?	□	□	
Frequent diarrhea?	□	□	
Painful bowel movements or constipation?	□	□	
Rectal bleeding or blood in stool?	□	□	
Abdominal pain or heartburn?	□	□	
Peptic ulcer disease?	□	□	
Any history of liver disease or hepatitis?	□	□	
Have you ever had a endoscopy or colonoscopy before?	□	□	
GENITOURINARY	Yes	No	
Do you have frequent urination?	□	□	
Burning or painful urination?	□	□	
Blood in urine?	□	□	
Change in force of strain when urinating?	□	□	
Incontinence or dribbling?	□	□	
Kidney stones?	□	□	
Sexual difficulty?	□	□	
Male- testicule pain?	□	□	
Female- pain with periods?	□	□	
Female- irregular periods?	□	□	
Female- vaginal discharge?	□	□	
Female- How many pregnancies?			Pregnancies: _____
Female- How many miscarriages?			Miscarriages: _____
Female- Any abnormal PAP smears?	□	□	When was your last PAP smear? _____
MUSCULOSKELETAL	Yes	No	

	Yes	No	Comments
Do you have joint pain?	□	□	
Joint stiffness or swelling?	□	□	
Weakness of muscles or joints?	□	□	
Muscle pain or cramps?	□	□	
Back Pain?	□	□	
Cold extremities?	□	□	
Difficult walking?	□	□	
INTEGUMENTARY (skin, breast)	Yes	No	
Do you have any rash or itching?	□	□	
Change in skin color?	□	□	
Change in hair or nails?	□	□	
Varicose veins?	□	□	
Breast pain, lump or discharge?	□	□	
NEUROLOGICAL	Yes	No	
Do you have frequent or recurring headaches?	□	□	
Lightheaded or dizziness?	□	□	
Convulsion or seizures?	□	□	
Numbness or tingling sensations?	□	□	
Tremors?	□	□	
Paralysis?	□	□	
Stroke?	□	□	
Head injury?	□	□	
PSYCHIATRIC	Yes	No	
Do you have memory loss or confusion?	□	□	
Nervousness?	□	□	
Depression?	□	□	
Insomnia?	□	□	
ENDOCRINE	Yes	No	
Do you have glandular or hormone problems?	□	□	
Thyroid disease?	□	□	
Diabetes?	□	□	
Excessive thirst or urination?	□	□	
Heat or cold intolerance?	□	□	
HEMATOLOGIC/LYMPHATIC	Yes	No	
Are you slow to heal after cuts?	□	□	

	Yes	No	Comments
Do you have any bleeding or bruising tendency?	□	□	
Anemia or low blood count?	□	□	
Phlebitis or blood clot?	□	□	
Past blood transfusion?	□	□	
Enlarged glands?	□	□	
ALLERGIC/IMMUNOLOGIC	Yes	No	
Do you have any history of skin reaction or other adverse reaction to:	□	□	
Penicillin or or antibiotics?	□	□	
Morphine, Demerol or other narcotics?	□	□	
Novocaine or other anesthetics?	□	□	
Aspirin or other pain remedies?	□	□	
Tetanus vaccines or other serums/ vaccines?	□	□	
Iodine, methiolate or other antiseptics?	□	□	
Other drugs/medications?	□	□	Please list: _____
Food allergies?	□	□	Please list: _____
SOCIAL HISTORY	Yes	No	
Do you use tobacco?	□	□	
Do you use alcohol?	□	□	
Do you use drugs?	□	□	
Do you work?	□	□	Occupation:_____
FAMILY HISTORY	Yes	No	
Relatives (current age or age at death)	Alive	Died	Cause of death/Disease
Father: age _____	□	□	
Mother: age _____	□	□	
List brothers/sisters with age	Alive	Died	List any disease or cause of death
	□	□	
	□	□	
	□	□	
	□	□	
	□	□	
	□	□	