Physical Questionnaire Annual – Adult Patients

Name____ Date:______________________________

DOB____ Age: ______________________________

Since your last examination please update us on the following: check all that apply

Personal habits (smoking, diet, alcohol use): No change _______ Change _______ please explain__________________________

Exercise: Are you currently exercising at least three times a week? (Circle) No Yes If yes, what:__________________________

Allergies: No new allergies _______ New allergy or drug reaction _______ Describe: ___________________________________

Medications: No change in regular medication _______ New medication or change in dose ________________________________

Significant illnesses: No significant illness since last physical _______ New diagnosis or event_____________________________

Hospitalization or Surgery: None since last physical _______ Hosp./Surgery _______ Describe____________________________

Family Medical History: No changes _______ New development____

Personal Social History: Have there been any significant changes in your work, home, or family environment? (Circle) Yes No
If so, please explain:

SYSTEMS REVIEW: Please indicate those items that have been a recurrent problem or a recent significant change.

Yes	No	Constitutional Symptoms
		Good health lately
____	____	Recent significant weight change
____	____	Unusual fatigue or weakness
____	____	Frequent headaches
		Eyes
____	____	Change in vision
____	____	Blurred or double vision
____	____	Eye disease or injury
____	____	Wear glasses/contact lenses?
		Ears/Nose/Mouth/Throat/Neck
____	____	Do you wear hearing aids?
____	____	Hearing loss or ringing in ears?
____	____	Earaches or drainage?
____	____	Chronic sinus problems or runny nose
____	____	Nose bleeds
____	____	Mouth sores
____	____	Bleeding gums
____	____	Sore throat/hoarseness or voice change
____	____	Lumps or swollen glands in neck
____	____	Difficulty swallowing
____	____	Neck pain or stiffness
		Cardiovascular
____	____	Heart trouble
____	____	Chest pain or angina pectoris
____	____	Palpitations
____	____	Shortness of breath with walking or lying flat
____	____	Swelling feet, ankles or hands
____	____	Waking at night with shortness of breath

Yes	No	Respiratory
____	____	Chronic or frequent cough
____	____	Coughing or spitting up blood
____	____	Shortness of breath
____	____	Asthma or recurrent wheezing
		Gastrointestinal
____	____	Loss of appetite
____	____	Change in bowel movements
____	____	Nausea or vomiting
____	____	Painful bowel movements or constipation
____	____	Frequent diarrhea
____	____	Rectal bleeding or blood in stool
____	____	Stomach/abdominal pains or heartburn
____	____	Black or tarry stools
		Genitourinary
____	____	Frequent urination
____	____	Burning or pain on urination
____	____	Blood in urine
____	____	Change in force or strain when urinating
____	____	Incontinence or dribbling of urine
____	____	Sexual difficulties
____	____	Men: Testicular pain
____	____	Women: Painful periods
____	____	Irregular periods
____	____	Recurrent vaginal discharge

Method of birth control (if applicable)___________________

Menopausal, since when: ___________________________

Date of last menstrual period:_______________________

Physical Questionnaire Annual – Adult Patient (continued)

Date of last Pap smear:______________________________

Date of last mammogram:_____________________________

Yes	No	Musculoskeletal
____	____	Joint pain(s)
____	____	Joint stiffness/swelling or warmth
____	____	Weakness of muscles or joints
____	____	Muscle pain or recurrent cramps
____	____	Back pain
____	____	Cold hands or feet
____	____	Difficulty in walking
		Integumentary (Skin/Breast)
____	____	Rashes or itching
____	____	Change in skin color or moles
____	____	Change in hair or nails
____	____	Varicose veins
____	____	Breast pain
____	____	Breast lump
____	____	Breast discharge or rash
		Neurological
____	____	Frequent, recurring or increasing headaches
____	____	Light-headedness or dizziness
____	____	Convulsions, seizures or spasms
____	____	Numbness or tingling sensations
____	____	Tremors
____	____	Paralysis
____	____	Stroke
____	____	Head injury
		Psychiatric
____	____	Memory loss or confusion
____	____	Nervousness
____	____	Insomnia
____	____	Depression

Yes	No	Endocrine
____	____	Glandular or hormone problem
____	____	Heat or cold intolerance
____	____	Excessive skin dryness
____	____	Excessive thirst or urination
____	____	Change in hand or glove size
		Hematologic / Lymphatic
____	____	Slow to heal after cuts or wounds
____	____	Bleeding or bruising tendency
____	____	Recurrent anemia
____	____	Swelling, warmth or tenderness of veins or history of phlebitis
		Allergic / Immunologic
____	____	History of skin reaction or other adverse reaction to:__________________________
____	____	Penicillin or other antibiotic: describe reaction:__________________________
____	____	Morphine, Demerol or other narcotics reaction:__________________________
____	____	Novocaine or other anesthetics reaction:__________________________
____	____	Aspirin or other pain remedies reaction:__________________________
____	____	Tetanus antitoxin or other serums
____	____	Iodine, methiolate or other antiseptic
____	____	Other medications:____________________
____	____	Other known food allergies______________

Patient signature________________________________

Date:____

Reviewed by:____________________________________

Date:____

HX

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Physician/ Signature:____________________________

Date:____

Patient Name:__________________________________