Name: Date:

YEARLY PHYSICAL EXAM - Part A

1) Current problems:

2) Describe illnesses or medical problems since your last physical:

3) List any surgeries or accidents since your last physical:

4) Changes in family history (give illness & family relationship):

5) Describe significant changes in your work/family situation:

Name: Date:

YEARLY PHYSICAL EXAM - Part A

6) MEDICATIONS & DIETARY SUPPLEMENTS

Please list all medications and dietary supplements that are taken once or more per week.

Prescriptions/Medications	Dose	How often Taken?	Reason for taking it
Over-the-counter Medications	Dose	How often Taken?	Reason for taking it
Dietary supplements (vitamins, minerals, herbs)	Dose	How often Taken?	Reason for taking it

7) ALLERGIES

Please list any allergies that you have to the following and explain what happens:

Medication:
Food:
Environment:

8) CONCERNS ABOUT SKIN: Check all that apply

☐	Red Spots	☐	Dark Moles	☐	Age Spots
☐	Rosacea	☐	Broken Capillaries	☐	Wrinkles
☐	Sagging Skin	☐	Unwanted Hair	☐	Scars

9) OTHER PHYSICIANS

Please list any other physicians that you are currently seeing and for what purpose:

Physician's name & speciality	Phone number & address	Reason for seeing

Name: Date:

10a) REVIEW OF SYSTEMS

Please check the appropriate box below if you had any of the symptoms ***during the past year.***

	GENERAL
	Recent weight gain or loss
	Weakness or fatigue
	Fever
	Sleep difficulties
	SKIN
	Rashes/itching
	Lumps
	Sores
	New moles or changes in moles
	Dryness
	Changes in hair or nails
	HEAD
	Headache
	Head injury
	EYES
	Vision problems
	Wear corrective lenses
	Eye pain
	Redness
	Excessive tearing
	Double vision
	Blurred vision
	See spots, specks, or flashing lights
	Glaucoma
	Cataracts
	EARS
	Hearing loss
	Use hearing aids
	Ringing in the ears (tinnitus)
	Dizziness (rooms spins)
	Ear pain or infection
	NOSE & SINUSES
	Nasal stuffiness, discharge, or itching
	Hay fever
	Nosebleeds
	Sinus trouble
	MOUTH & THROAT
	Wear dentures
	Chewing problems
	Sore tongue
	Sores in mouth

	MOUTH & THROAT (continued)
	Dry mouth
	Frequent sore throats
	Hoarseness
	Bleeding gums
	NECK
	Lumps
	Swollen glands
	Goiter
	Neck pain or stiffness
	BREASTS
	Breast lumps
	Breast pain or discomfort
	Nipple discharge
	RESPIRATORY
	Dry cough
	Productive cough (sputum)
	Cough up blood
	Wheezing
	Frequent bronchitis
	Difficulty breathing at rest
	CARDIAC
	Difficulty breathing at exertion
	Difficulty breathing when lying flat
	Sudden difficulty breathing in sleep
	High blood pressure
	Heart murmurs
	Chest pain or discomfort
	Heart palpitations
	Swelling in feet
	GASTROINTESTINAL
	Trouble swallowing
	Heartburn
	Appetite changes
	Nausea or vomiting
	Indigestion
	Change in color or size of stools
	Change in frequency of stools
	Blood in stools or black tarry stools
	Hemorrhoids
	Constipation
	Diarrhea

Name: Date:

10b) REVIEW OF SYSTEMS

Please check the appropriate box below if you had any of the symptoms ***during the past year.***

	GASTROINTESTINAL (continued)
	Abdominal pain
	Food intolerance
	Excessive belching or gas
	Gallbladder problems
	URINARY
	Frequent need to urinate
	Wake up from sleep to urinate
	Burning or pain in urination
	Blood in urine
	Sense of urgency to urinate
	Reduced force of urinary stream
	Difficulty starting a stream
	Dribbling after stopping urination
	Incontinence of urine
	Urinary tract infection
	Kidney stones
	FEMALE GENITALIA
	Absent or irregular frequency of periods
	Change in cycle length/duration of period
	Increased blood clots during period
	Bleeding between periods
	Bleeding after sexual intercourse
	Painful cramping during periods
	Painful sexual intercourse
	Premenstrual symptoms
	Vaginal discharge or itching
	Vaginal sores or lumps
	Decreased sexual interest or function
	Exposure to DES during mother's pregnancy
	Menopausal symptoms
	Post-menopausal bleeding
	MALE GENITALIA
	Hernias
	Discharge or sores on penis
	Testicular pain or lumps
	Decreased sexual interest or function
	Erectile problems

	PERIPHERAL VASCULAR
	Pain in calves when walking
	Leg cramps
	Varicose veins
	Previous blood clots in leg
	MUSCLE-SKELETAL
	Muscle pain
	Joint pain or stiffness
	Gout
	Backache
	Difficulty walking
	Difficulty bending
	NEUROLOGIC
	Fainting or blackouts
	Paralysis
	Muscle weakness
	Numbness/loss of sensation in extremities
	Tingling or "pins and needles"
	Tremors or involuntary movements
	Difficulty getting to sleep
	Early morning wakening
	Other sleep problems (loud snoring)
	HEMATOLOGIC
	Anemia
	Easy bruising
	Prolonged bleeding from small cuts
	ENDOCRINE
	Thyroid trouble
	Heat and cold intolerance
	Excessive sweating
	Excessive thirst or hunger
	PSYCHIATRIC
	Nervousness/tension
	Mood swings
	Depression
	Memory changes
	OTHER (specify)

Name: Date:

YEARLY PHYSICAL EXAM - Part B

PREVENTATIVE HEALTH CARE QUESTIONS

The following questions are about your preventive health care. Your answers are very important even if some questions do not pertain to your lifestyle. Your answers will be used to plan your care according to your age, risk factors, and individual needs.

A) NUTRITION PROFILE:

1. Are you on a special diet now? If yes, please fully describe.

_____

_____

2. How many servings of the following food or beverages did you eat or drink YESTERDAY?

- ☐ Caffeine drinks(coffee, tea, soda/soft drink)
- ☐ Dairy products (milk, yogurt, cheese)
- ☐ Beer, wine or other alcoholic beverages
- ☐ Water
- ☐ Soda, seltzer
- ☐ Juices

3. How many servings of the following fruits and vegetables did you eat yesterday?

- ☐ Dark green vegetables (broccoli, spinach, chard)
- ☐ Yellow/orange colored fruits or vegetables (squash, sweet potato, cantaloupe, peach)
- ☐ Other fruits (not including juices)

4. How many servings of the following protein foods did you eat yesterday?

- ☐ Fish/shellfish
- ☐ Poultry
- ☐ Meat
- ☐ Nuts or seeds
- ☐ Peanut Butter
- ☐ Eggs
- ☐ Lentils or other dried beans

5. How many servings of the following foods did you eat yesterday?

- ☐ Cold cuts, hot dogs, or bacon
- ☐ French fries or other fried foods
- ☐ Cake, cookies, muffins, pastries, donuts, or pie
- ☐ Foods containing chocolate or cocoa
- ☐ Potato chips or other chip-type snack
- ☐ Margarine or other partially hydrogenated oil (oils other than olive or canola)

6. Is the way you ate yesterday the way you usually eat?

_____

_____

Name: Date:

YEARLY PHYSICAL EXAM - Part B

B) EXERCISE & SAFETY: **(Please fill the pertinent information in the boxes below)**

a) How many days / times during the past WEEK have you done the following:

1) a- Exercised for at least 20 minutes in sustained moderate exercise? ☐

b- What kind of exercise do you do? _____

2) Driven when you've had too much alcohol to drink? ☐

3) Used a cellular phone or texting while driving? ☐

b) How often do you use seat belts when you drive or ride in a car (including taxis)?

☐ Always ☐ Nearly Always ☐ Sometimes ☐ Seldom ☐ Never

c) Do you have at least one working smoke alarm in your home? _____

d) Have you ever been emotionally or physically abused by a partner or someone important to you? _____

e) Are you concerned about a potential violence within your home or nearby community?

C) TOBACCO, ALCOHOL, AND DRUGS:

1) Have you smoked at least 100 cigarettes in your entire life? ☐

2) Do you now smoke: ☐ a) Some days ☐ b) Every day; If so, how many a day ☐

3) If you currently smoke, would you like to quit now? ☐

4) During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking? ☐

5) Do you now use tobacco in other forms such as vaping, cigars or chewing tobacco? ☐

6) Have you ever used any drugs for recreational purposes? (include prescription drugs, marijuana, cocaine, heroin, LSD, ecstasy, etc.) ☐

If YES, during the past 12 months, have you used any of the above? ☐

7) On average, how many alcoholic drinks do you consume in a week? ☐

(one drink equals 1 ½ oz for liquor and 5 oz for wine)

8) What kinds of alcohol do you normally consume when you drink? _____

9) How many hours of uninterrupted sleep do you get on an average night? ☐

Name: Date:

YEARLY PHYSICAL EXAM - Part B

D) SEXUAL PARTNERS: (Please fill the pertinent information in the boxes below)

1) During the past 12 months, with how many people have you been sexually active with? ☐

2) Was barrier protection (condom, dental dam, etc.) used the last time you had sex? ☐

3) The past 5 years, have you been treated for a sexually transmitted disease? ☐

The following question identifies persons who are at risk for HIV and AIDS. Please answer yes if ANY of the statements are true. ***DO NOT indicate which ones are true.***

4) Are any ofthe following statements true? ☐ **Yes** ☐ **No**

a) I have had more than one sexual partner since 1980, and have not used condoms every time I have had sexual intercourse.
b) I have hemophilia and have received clotting factor concentrations.
c) I am male and have had sex with other men since 1980 (even once).
d) I have used IV street drugs.
e) I have had sexual partners since 1980 that could answer YES to the above questions.

E) DURING THE PAST WEEK:	Rarely or none of the time.	Some or little of the time (1 to 2 days)	Occasionally or a moderate amount (3 to 4 days)	Most or all of the time (5 to 7 days)
I was bothered by things that don't usually bother me.				
I did not fee like eating; my appetite was poor.				
I felt that I could not shake off the blues even with help from my family or friends.				
I felt that I was as good as other people.				
I had trouble keeping my mind on what I was doing.				
I felt depressed.				
I felt that everything I did was an effort.				
I felt hopeful about the future.				
I felt fearful.				
My sleep was restless.				
I was happy.				
I felt lonely.				
I enjoyed life.				
I felt sad.				
I could not get going.				