

Date: _____

Name: _____ DOB: _____

DESCRIBE ANY PROBLEMS YOU HAVE HAD SINCE YOUR LAST PHYSICAL:

	No	Yes		No	Yes
Constitutional:					
Good general health lately	_____	_____	Fever	_____	_____
Recent weight change	_____	_____	Fatigue	_____	_____
Headaches	_____	_____			
Eyes:					
Wear Glasses/contact lenses	_____	_____	Glaucoma	_____	_____
Blurred or double vision	_____	_____	Eye disease or injury	_____	_____
Ears/Nose/Mouth/Throat:					
Hearing loss or ringing	_____	_____	Nose bleeds	_____	_____
Chronic sinus problem/rhinitis	_____	_____	Mouth sores	_____	_____
Earaches or drainage	_____	_____	Bleeding gums	_____	_____
Sore throat or voice change	_____	_____	Swollen neck glands	_____	_____
Bad breath or bad taste	_____	_____			
Cardiac:					
Chest Pain	_____	_____	Palpitations	_____	_____
Problems with sleeping flat	_____	_____	Racing heart beat	_____	_____
Waking up short of breath	_____	_____	Ankle swelling	_____	_____
Respiratory:					
Wheezing	_____	_____	Cough	_____	_____
Coughing up blood	_____	_____	Sputum production	_____	_____
Trouble breathing on exertion	_____	_____			
GI:					
Nausea	_____	_____	Vomiting	_____	_____
Redblood in stools	_____	_____	Black stools	_____	_____
Change in bowel habit	_____	_____	Diarrhea	_____	_____
Constipation	_____	_____			
GU:					
Urinating frequently	_____	_____	Blood in urine	_____	_____
Pain with urination	_____	_____	Getting up late at night to urinate	_____	_____
Musculoskeletal:					
Joint Stiffness or swelling	_____	_____	Joint Pain	_____	_____
Weakness of muscles or joints	_____	_____	Back Pain	_____	_____
Muscle pain or cramps	_____	_____	Cold extremities	_____	_____
Difficulty in walking	_____	_____			

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	No	Yes		No	Yes
Neuro:					
Headaches	_____	_____	Vision problems	_____	_____
Balance difficulty	_____	_____	Weakness	_____	_____
Speech problems	_____	_____	Stroke symptoms	_____	_____
Numbness	_____	_____	Tremors	_____	_____
Psychiatric:					
Memory loss or confusion	_____	_____	Nervousness	_____	_____
Depression	_____	_____	Insomnia	_____	_____
Skin:					
Changing moles	_____	_____	Rash	_____	_____
Moles	_____	_____	Varicose veins	_____	_____
Breast pain	_____	_____	Breast lump	_____	_____
Breast discharge	_____	_____			
Endocrine:					
Excessive thirst or urination	_____	_____	Thyroid disease	_____	_____
Heat or cold intolerance	_____	_____	Diabetes	_____	_____
Hematologic/Lymphatic:					
Bleeding or bruising tendency	_____	_____	Anemia	_____	_____
Past transfusion	_____	_____			

Allergic/Immunologic: _____

History of skin reaction or other adverse reaction to : _____

	Yes	No
Penicillin or other antibiotics	_____	_____
Morphine, Demerol, or other narcotics	_____	_____
Novocaine or other anesthetics	_____	_____
Aspirin or other pain remedies	_____	_____
Tetanus antitoxin or other serums	_____	_____
Iodine, methiolate or other antiseptic	_____	_____
Other drugs/medication: _____		
Known food allergies: _____		

Changes in family history? : _____

Any surgeries in the past year? _____

Taking any new medications? _____

Preferred Pharmacy to use for refills and new prescriptions _____