Annual Physical Review

Name: _____ Reason for Visit: _____

Address: _____ Phone: _____

Date of Visit: _____ DOB: _____ Age: _____ Occupation: _____

Primary Care Physician & Phone #: _____

***ALLERGIES: _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Menstrual History:

Last Menstrual Period: _____

Days of Flow: _____ Amount: *(heavy, normal, light)* _____ Length Between Periods: _____

Have you ever been pregnant? ☐ Yes ☐ No

How many times: _____

Full Term _____ # Pre Term _____ # Miscarriage / Abortion _____ # Living Children _____

Any pregnancy complications: _____

Do you use birth control?

☐ Pills ☐ Diaphragm ☐ Depo Provera ☐ Norplant ☐ Abstinence ☐ None Needed

☐ IUD ☐ Vasectomy ☐ Tubal Ligation ☐ Condoms ☐ Rhythm Method

Do you use hormone replacement? ☐ Yes ☐ No Rx: _____

Medical History: *Check if you have had any of the following:*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Anemia	☐	☐	Depression
☐	☐	Abnormal Pap Smear	☐	☐	Heart Disease	☐	☐	Thyroid Problems	☐	☐	Alcoholism
☐	☐	Pelvic Infection	☐	☐	Mitral Valve Prolapse	☐	☐	Diabetes	☐	☐	Digestive Problems
☐	☐	Sexually Transmitted Disease	☐	☐	High Cholesterol	☐	☐	Tuberculosis	☐	☐	Drug Addiction
☐	☐	Phlebitis / Blood Clots in Legs	☐	☐	Migraine Headaches	☐	☐	Hepatitis	☐	☐	Infertility

Date of Last: Colonoscopy _____ Bone Density _____ HPV vaccine _____ (Gardasil) _____

	Yes	No	
Do you perform breast exams on yourself?	☐	☐	How often? _____
Have you had a mammogram of your breasts?	☐	☐	If so, when? _____
Have you ever had an abnormal mammogram?	☐	☐	If so, when? _____
Have you ever had an abnormal pap smear?	☐	☐	If yes, What kind of treatment? _____
Do you have a pap Smear Yearly?	☐	☐	
Do you take any other medications	☐	☐	Please List _____

Surgical History:

Have you had any female surgery? Yes ☐ No ☐ If so, what type? (check below):

☐ Breast ☐ Hysterectomy ☐ D&C ☐ Ectopic Pregnancy ☐ Fibroid Tumors

☐ Ovary ☐ Laparoscopy ☐ Cesarean Section ☐ Laser/LEEP/Cryo of Cervix ☐ Other

Reason for Surgery / Findings _____

Please list any other surgery: *(i.e., appendectomy, heart surgery)* _____

Review by: _____ ***(Please complete back side of page)***

	Yes	No		
Have you ever smoked?	☐	☐	How Much? _____	☐ Quit Years? _____
Do you drink alcohol?	☐	☐	How Much? _____	How Often? _____
Do you use street drugs?	☐	☐	What Kind? _____	How Often? _____
Are you at risk for HIV infection?	☐	☐		
Are you or have you ever been threatened or physically, sexually or mentally abused?	☐	☐		

Family History: *(Siblings, Parents, Grandparents)*

Please check (✓) appropriate box if a family member currently has or previously had one of these illnesses. Check every listing.

Yes	No			Yes	No		
☐	☐	Breast Cancer	_____	☐	☐	Tuberculosis	_____
☐	☐	Ovarian Cancer	_____	☐	☐	Diabetes	_____
☐	☐	Other Cancer	_____	☐	☐	Bleeding Disorder	_____
☐	☐	Birth Defects	_____	☐	☐	Alcoholism	_____
☐	☐	High Blood Pressure	_____	☐	☐	Mental Retardation	_____
☐	☐	Heart Attack	_____	☐	☐	Other	_____
☐	☐	High Cholesterol	_____				

REVIEW OF SYSTEMS - *Please check if you are having problems with any of the following:*

Genital / Urinary

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Vaginal Warts	☐	☐	Heavy Vaginal Bleeding	☐	☐	Painful Intercourse	☐	☐	Urination at Night
☐	☐	Vaginal Dryness	☐	☐	Irregular Vaginal Bleeding	☐	☐	Urinary Urgency	☐	☐	Bladder Control / Leakage
			☐	☐	Painful Menstrual Periods	☐	☐	Pain / Burning with Urination	☐	☐	Urinary Tract Infections

Endocrine

☐	☐	Fatigue	☐	☐	Hair Loss	☐	☐	Absence of Menstrual Periods	☐	☐	Hot Flashes

Skin / Breast

☐	☐	Nipple Discharge	☐	☐	Sore That Does Not Heal	☐	☐	Changes in Mole	☐	☐	Rashes / Persistent Itching
☐	☐	Breast Lumps / Tenderness									

Neurological

☐	☐	Frequent Headaches	☐	☐	Poor Coordination	☐	☐	Muscle Weakness	☐	☐	Trouble Sleeping

Psychiatric

☐	☐	Depression	☐	☐	Anxiety	☐	☐	Memory Changes	☐	☐	Counseling or Treatment
☐	☐	Mood Swings									

ENT

☐	☐	Visual Problems	☐	☐	Allergies / Hayfever	☐	☐	Frequent Sore Throat	☐	☐	Mouth Ulcers
☐	☐	Hearing Loss	☐	☐	Hoarseness	☐	☐	Sinus Problems			

Digestive

☐	☐	Heart Burn	☐	☐	Rectal Bleeding	☐	☐	Diarrhea	☐	☐	Yellow Jaundice
☐	☐	Vomiting	☐	☐	Black Stools	☐	☐	Significant Weight Change (i.e., < or > 10-15 lbs. / yr.)			

Cardiac

☐	☐	Chest Pain	☐	☐	Irregular Heart Beat	☐	☐	Fainting / Dizziness			

Respiratory

☐	☐	Shortness of Breath	☐	☐	Coughed Blood	☐	☐	Wheezing			