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)***

CHS-600 (10/08)

Social History / Habits:

	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
- ☐ ☐ Vaginal Warts
- ☐ ☐ Vaginal Dryness
- ☐ ☐ Heavy Vaginal Bleeding
- ☐ ☐ Irregular Vaginal Bleeding
- ☐ ☐ Painful Menstrual Periods
- ☐ ☐ Painful Intercourse
- ☐ ☐ Urinary Urgency
- ☐ ☐ Pain / Burning with Urination
- ☐ ☐ Urination at Night
- ☐ ☐ Bladder Control / Leakage
- ☐ ☐ Urinary Tract Infections

Endocrine

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

Skin / Breast

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

Neurological

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

Psychiatric

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

ENT

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

Digestive

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

Cardiac

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

Respiratory

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