Annual Physical Review

Name: _____Reason for Visit: _____

Address: _____ Phone: _____

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

Primary Care Physician Name & Phone #: _____

***ALLERGIES:** _____

List of Current Medicines: _____

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? _____

Baby #1 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Baby #2 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Baby #3 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Baby #4 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Baby #5 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Living Children _____

Any pregnancy complications: _____

Do you use birth control?

Pills _____ Diaphragm _____ Depo Provera _____ Implanon/Nexplanon _____ Abstinence _____ None Needed ____

IUD _____ Vasectomy _____ Tubal Ligation _____ Condoms _____ NuvaRing_____ Rhythm Method _____

Do you use hormone replacement? Yes _____ No _____ Prescription Name: _____

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

Yes___ No___ Cancer

Yes ___ No___ High Blood Pressure

Yes___ No ___ Anemia

Yes___ No ___ Depression

Yes___ No___ Abnormal Pap Smear

Yes ___ No___ Heart Disease

Yes___ No___ Thyroid Problems

Yes___ No___ Alcoholism

Yes___ No___ Pelvic Infection

Yes___ No ___ Mitral Valve Prolapse

Yes___ No___ Diabetes

Yes___ No___ Digestive Problems

Yes___ No ___ Sexually Transmitted Disease

Yes ___ No ___ High Cholesterol

Yes___ No ___ Tuberculosis

Yes___ No ___ Drug Addiction

Yes___ No ___ Phlebitis/Blood Clots in legs

Yes ___No ___Migraine Headaches

Yes__ No ___ Hepatitis

Yes___ No ___ Infertility

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

Do you perform breast exams on yourself? Yes___ No___ How often? _____

Have you had a mammogram of your breasts? Yes___ No___ If so, when? _____

Have you ever had an abnormal mammogram? Yes___ No___ If so, when? _____

Have you ever had an abnormal pap smear? Yes___ No___ If yes, what kind of treatment? _____

Do you have a pap smear yearly? Yes___ No___

Surgical History:

Have you had any female surgery? If so, what type and what year?

Breast _____ Hysterectomy_____ D&C_____ Ectopic Pregnancy_____ Fibroid Tumors_____

Ovary_____ Laparoscopy_____ C-section_____ Laser/LEEP/Cryo of Cervix_____ Other_____

Reason for Surgery / Findings: _____

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

Social History / Habits:

Have you ever smoked? Yes___ No___ How much? _____ Quit?_____ Years?_____

Do you drink alcohol? Yes___ No___ How much? _____ How often? _____

Do you use street drugs? Yes___ No___ What kind? _____ How often? _____

Are you at risk for HIV infection? Yes___ No___

Are you or have you ever been threatened or physically, sexually or mentally abused? Yes___ No___

Do you exercise? Yes___ No___ How often? _____

Family History: (Siblings, Parents, Grandparents)
Please mark appropriate box if a family member currently has or previously had one of these illnesses. Check every listing.

Yes___ No___ Breast Cancer

Yes___ No___ Ovarian Cancer

Yes___ No___ Other Cancer

Yes___ No___ Birth Defects

Yes___ No___ High Blood Pressure

Yes___ No___ Heart Attack

Yes___ No___ High Cholesterol

Yes___ No___ Tuberculosis

Yes___ No ___ Diabetes

Yes___ No___ Bleeding Disorder

Yes ___ No___ Alcoholism

Yes___ No___ Mental Retardation

Yes___ No___ Osteoporosis/Osteopenia

Yes___ No___ Other

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

Genital / Urinary

Yes___ No___ Vaginal Warts

Yes___ No___ Vaginal Dryness

Yes___ No___ Heavy Vaginal Bleeding

Yes___ No___ Irregular Vaginal Bleeding

Yes___ No___ Painful Menstrual Periods

Yes___ No___ Painful Intercourse

Yes___ No___ Urinary Urgency

Yes___ No___ Pain / Burning with Urination

Yes___ No___ Urination at night Yes___ No___ Bladder Control / Leakage Yes___ No___ Urinary Tract Infections

---

Endocrine

Yes___ No___ Fatigue Yes___ No___ Hair Loss Yes___ No___ Absence of Menstrual Periods Yes___ No___ Hot Flashes

---

Skin / Breast

Yes___ No___ Nipple Discharge Yes___ No___ Sore that Does Not Heal Yes___ No___ Changes in Mole

Yes___ No___ Breast Lumps Yes___ No___ Breast Tenderness Yes___ No___ Rashes / Persistent Itching

---

Neurological

Yes___ No___ Frequent Headaches Yes___ No___ Poor Coordination

Yes___ No___ Muscle Weakness Yes___ No___ Trouble Sleeping

Psychiatric

Yes___ No___ Depression Yes___ No___ Anxiety Yes___ No___ Memory Changes

Yes___ No___ Mood Swings Yes___ No___ Counseling Treatment

Ear, Nose & Throat

Yes___ No___ Visual Problems Yes___ No___ Allergies / Hayfever Yes___ No___ Frequent Sore Throats

Yes___ No___ Mouth Ulcers Yes___ No___ Hearing Loss Yes___ No___ Hoarseness

Yes___ No___ Sinus Problems

Digestive

Yes___ No___ Heartburn Yes___ No___ Rectal Bleeding Yes___ No___ Diarrhea Yes___ No___ Yellow Jaundice

Yes___ No___ Vomiting Yes___ No___ Black Stools Yes___ No___ Significant Weight Change (i.e. < or > 10-15 lbs. / year)

Cardiac

Yes___ No___ Chest Pain Yes___ No___ Irregular Heart Beat Yes___ No___ Fainting / Dizziness

---

Respiratory

Yes___ No___ Shortness of Breath Yes___ No___ Coughed Blood Yes___ No___ Wheezing

---