

Physical Questionnaire Annual – Adult Patients

Name _____

Date: _____

DOB _____ Age _____

Form Completed by: _____

Since your last examination please update us on the following: *check all that apply*

Personal habits (smoking, diet, alcohol use): No change _____ Change _____ *please explain* _____

Exercise: Are you currently exercising at least three times a week? (*circle*) No Yes If yes, what: _____

Allergies: No new allergies _____ New allergy or drug reaction _____ *Describe:* _____

Medications: No change in regular medication _____ New medication or change in dose _____

Significant illnesses: No significant illness since last physical _____ New diagnosis or event _____

Hospitalization or Surgery: None since last physical _____ Hosp./Surgery _____ *Describe* _____

Family Medical History: No changes _____ New development _____

Personal Social History: Have there been any significant changes in your work, home, or family environment? (*Circle*) Yes No
If so, please explain:

SYSTEMS REVIEW: Please indicate those items that have been a recurrent problem or a recent significant change.

Yes	No		Yes	No	
___	___	Constitutional Symptoms	___	___	Respiratory
___	___	Good health lately	___	___	Chronic or frequent cough
___	___	Recent significant weight change	___	___	Coughing or spitting up blood
___	___	Unusual fatigue or weakness	___	___	Shortness of breath
___	___	Frequent headaches	___	___	Asthma or recurrent wheezing
		Eyes			Gastrointestinal
___	___	Change in vision	___	___	Loss of appetite
___	___	Blurred or double vision	___	___	Change in bowel movements
___	___	Eye disease or injury	___	___	Nausea or vomiting
___	___	Wear glasses/contact lenses?	___	___	Painful bowel movements or constipation
		Ears/Nose/Mouth/Throat/Neck	___	___	Frequent diarrhea
___	___	Do you wear hearing aids?	___	___	Rectal bleeding or blood in stool
___	___	Hearing loss or ringing in ears?	___	___	Stomach/abdominal pains or heartburn
___	___	Earaches or drainage?	___	___	Black or tarry stools
___	___	Chronic sinus problems or runny nose			Genitourinary
___	___	Nose bleeds	___	___	Frequent urination
___	___	Mouth sores	___	___	Burning or pain on urination
___	___	Bleeding gums	___	___	Blood in urine
___	___	Sore throat/hoarseness or voice change	___	___	Change in force or strain when urinating
___	___	Lumps or swollen glands in neck	___	___	Incontinence or dribbling of urine
___	___	Difficulty swallowing	___	___	Sexual difficulties
___	___	Neck pain or stiffness	___	___	Men: Testicular pain
		Cardiovascular	___	___	Women: Painful periods
___	___	Heart trouble	___	___	Irregular periods
___	___	Chest pain or angina pectoris	___	___	Recurrent vaginal discharge
___	___	Palpitations			Method of birth control (if applicable) _____
___	___	Shortness of breath with walking or lying flat			Menopausal, since when: _____
___	___	Swelling feet, ankles or hands			Date of last menstrual period: _____
___	___	Waking at night with shortness of breath			<i>Continues on back</i>

Physical Questionnaire Annual – Adult Patient (continued)

Date of last pap smear: _____

Date of last mammogram: _____

- | | | |
|------------|-----------|------------------------------------|
| Yes | No | Musculoskeletal |
| _____ | _____ | Joint pain(s) |
| _____ | _____ | Joint stiffness/swelling or warmth |
| _____ | _____ | Weakness of muscles or joints |
| _____ | _____ | Muscle pain or recurrent cramps |
| _____ | _____ | Back pain |
| _____ | _____ | Cold hands or feet |
| _____ | _____ | Difficulty in walking |

Integumentary (Skin/Breast)

- | | | |
|-------|-------|-------------------------------|
| _____ | _____ | Rashes or itching |
| _____ | _____ | Change in skin color or moles |
| _____ | _____ | Change in hair or nails |
| _____ | _____ | Varicose veins |
| _____ | _____ | Breast pain |
| _____ | _____ | Breast lump |
| _____ | _____ | Breast discharge or rash |

Neurological

- | | | |
|-------|-------|---|
| _____ | _____ | Frequent, recurring or increasing headaches |
| _____ | _____ | Light-headedness or dizziness |
| _____ | _____ | Convulsions, seizures or spasms |
| _____ | _____ | Numbness or tingling sensations |
| _____ | _____ | Tremors |
| _____ | _____ | Paralysis |
| _____ | _____ | Stroke |
| _____ | _____ | Head injury |

Psychiatric

- | | | |
|-------|-------|--------------------------|
| _____ | _____ | Memory loss or confusion |
| _____ | _____ | Nervousness |
| _____ | _____ | Insomnia |
| _____ | _____ | Depression |

- | | | |
|------------|-----------|---|
| Yes | No | Endocrine |
| _____ | _____ | Glandular or hormone problem |
| _____ | _____ | Heat or cold intolerance |
| _____ | _____ | Excessive skin dryness |
| _____ | _____ | Excessive thirst or urination |
| _____ | _____ | Change in hand or glove size |
| _____ | _____ | Hematologic / Lymphatic |
| _____ | _____ | Slow to heal after cuts or wounds |
| _____ | _____ | Bleeding or bruising tendency |
| _____ | _____ | Recurrent anemia |
| _____ | _____ | Swelling, warmth or tenderness of veins or history of phlebitis |
| _____ | _____ | Allergic / Immunologic |
| _____ | _____ | History of skin reaction or other adverse reaction to: _____ |
| _____ | _____ | Penicillin or other antibiotic: describe reaction: _____ |
| _____ | _____ | Morphine, Demerol or other narcotics reaction: _____ |
| _____ | _____ | Novocaine or other anesthetics reaction: _____ |
| _____ | _____ | Aspirin or other pain remedies reaction: _____ |
| _____ | _____ | Tetanus antitoxin or other serums |
| _____ | _____ | Iodine, methiolate or other antiseptic |
| _____ | _____ | Other medications: _____ |
| _____ | _____ | Other known food allergies _____ |

Patient signature _____

Reviewed by: _____

Date: _____

Date: _____

HX: _____

Physician/ARNP Signature: _____

Date: _____

Patient Name: _____