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	Constitutional Symptoms
____	____	Good health lately
____	____	Recent significant weight change
____	____	Unusual fatigue or weakness
____	____	Frequent headaches
		Eyes
____	____	Change in vision
____	____	Blurred or double vision
____	____	Eye disease or injury
____	____	Wear glasses/contact lenses?
		Ears/Nose/Mouth/Throat/Neck
____	____	Do you wear hearing aids?
____	____	Hearing loss or ringing in ears?
____	____	Earaches or drainage?
____	____	Chronic sinus problems or runny nose
____	____	Nose bleeds
____	____	Mouth sores
____	____	Bleeding gums
____	____	Sore throat/hoarseness or voice change
____	____	Lumps or swollen glands in neck
____	____	Difficulty swallowing
____	____	Neck pain or stiffness
		Cardiovascular
____	____	Heart trouble
____	____	Chest pain or angina pectoris
____	____	Palpitations
____	____	Shortness of breath with walking or lying flat
____	____	Swelling feet, ankles or hands
____	____	Waking at night with shortness of breath

Yes	No	Respiratory
____	____	Chronic or frequent cough
____	____	Coughing or spitting up blood
____	____	Shortness of breath
____	____	Asthma or recurrent wheezing
		Gastrointestinal
____	____	Loss of appetite
____	____	Change in bowel movements
____	____	Nausea or vomiting
____	____	Painful bowel movements or constipation
____	____	Frequent diarrhea
____	____	Rectal bleeding or blood in stool
____	____	Stomach/abdominal pains or heartburn
____	____	Black or tarry stools
		Genitourinary
____	____	Frequent urination
____	____	Burning or pain on urination
____	____	Blood in urine
____	____	Change in force or strain when urinating
____	____	Incontinence or dribbling of urine
____	____	Sexual difficulties
____	____	Men: Testicular pain
____	____	Women: Painful periods
____	____	Irregular periods
____	____	Recurrent vaginal discharge

Method of birth control (if applicable)_____

Menopausal, since when: _____

Date of last menstrual period:_____

Continues on back

BayCare Medical Group

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 tendance
____	____	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 antiobiotic: 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_____

Date:_____

Reviewed by:_____

Date:_____

HX:_____

Physician/ARNP Signature:_____

Date:_____

Patient Name:_____