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)***

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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		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