

Since your last annual exam . . .

Name _____

Constitutional

Seat Belt Use Yes No
 Regular Exercise Yes No
 Recent weight gain No Yes
 Recent weight loss No Yes
 Chronic fatigue No Yes

Eyes

Eye injury No Yes
 Glaucoma No Yes
 Blurred vision No Yes
 Double vision No Yes
 Do you wear glasses/contacts No Yes

Head, Ears, Nose, Mouth, Throat

Dizziness No Yes
 Frequent sinus infections No Yes
 Ear problems No Yes
 Impaired hearing No Yes
 Frequent itchy/runny nose No Yes
 Frequent nosebleeds No Yes
 Frequent mouth sores No Yes
 Frequent sore throats No Yes
 Hoarseness No Yes

Breasts

Monthly self breast exams Yes No
 Breast tenderness No Yes
 Breast swelling No Yes
 Breast lumps No Yes
 Nipple discharge No Yes
 Currently breast feeding No Yes

Cardiovascular

Chest pain or angina No Yes
 Heart attack No Yes
 Heart murmur No Yes
 Shortness of breath with exertion No Yes
 Shortness of breath at all times No Yes
 Swelling of hands, feet or ankles No Yes
 Varicose veins No Yes
 Phlebitis (inflammation or clots in veins) No Yes

Respiratory

Difficulty breathing No Yes
 Wheezing No Yes
 Coughing up blood No Yes
 Current common "cold" symptoms No Yes
 Chronic cough No Yes
 Frequent bronchitis No Yes

Gastrointestinal

Loss of appetite No Yes
 Heartburn No Yes
 Indigestion No Yes
 Vomiting blood No Yes
 Gallbladder disease No Yes
 Cramping or pain in the abdomen No Yes
 Hemorrhoids No Yes
 Constipation No Yes
 Frequent diarrhea No Yes
 Change in bowel habits No Yes
 Painful bowel movements No Yes
 Bleeding with bowel movements No Yes
 Black or tarry stools No Yes
 Incontinent of stool No Yes

Genitourinary

Irregular menstrual periods No Yes
 Pelvic pain No yes
 Vaginal dryness No Yes
 Vaginal itching No Yes
 Vaginal odor No Yes
 History multiple sexual partners (5+) No Yes

Recent new sexual partner No Yes
 History of sexually transmitted infection No Yes
 Onset of sexual activity <17 years No Yes
 Painful intercourse No Yes
 Involuntary loss of urine No Yes
 Frequent urination No Yes
 Nighttime urination No Yes
 Burning/painful urination No Yes
 Blood in urine No Yes
 Change in urine color No Yes
 Foul smelling urine No Yes
 Pregnancy since last visit No Yes
 Chance you might be pregnant today No Yes
 First day of your last menstrual period _____

Skin

New lesions No Yes
 Changes in moles (color, shape, itching, irritation) No Yes
 Rashes No Yes
 Eczema No Yes
 Psoriasis No Yes
 Frequent infections or boils No Yes
 Jaundice (yellow skin and eyes) No Yes
 Frequent tanning/bed use No Yes

Neurological

Frequent headaches No Yes
 Current or past fainting spells No Yes
 Memory difficulties No Yes
 Balance difficulties No Yes
 Seizures No Yes
 Tremors No Yes
 Lack of coordination No Yes
 Numbness or tingling No Yes

Musculoskeletal

Any physical disabilities No Yes
 Frequent back pain No Yes
 Joint pain No Yes
 Joint stiffness No Yes
 Joint swelling No Yes

Endocrine

Hormone therapy No Yes
 Hair loss No Yes
 Facial hair growth No Yes
 Intolerant to heat and cold No Yes
 Skin overly dry No Yes
 Excessive thirst No Yes
 Excessive urination No Yes
 Hot flashes No Yes
 Night sweats No Yes

Psychiatric

Psychiatric diagnosis No Yes
 Hospitalized for psychiatric reasons No Yes
 Attempted to hurt yourself or others No Yes
 Anxiety No Yes
 Panic attacks No Yes
 Depression No Yes
 Difficulty sleeping No Yes
 Eating disorders No Yes

Hematologic/Lymphatic

Anemia No Yes
 Experience excessive bleeding No Yes
 Do you bruise easily No Yes
 Received a blood transfusion No Yes
 Any unusual swelling or lumps No Yes

Allergic/Immunologic

Seasonal allergic symptoms	No	Yes
Tetanus immunization in last 10 yrs	Yes	No
Are you sick a lot	No	Yes
History of chicken pox or immunity	Yes	No

Other

Do you have any other problems	No	Yes
Do you have any questions for us	No	Yes

Comments _____
