

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** \_\_\_\_\_

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