# Physical Questionnaire

**Please list any other medical providers/specialty involved in your healthcare.**

_____ _____ _____

_____ _____ _____

**Please list all your medical conditions:**

_____ _____ _____

_____ _____ _____

**Please list all medications you are taking (over the counter as well), dosage and how many times a day.**

_____ _____ _____

_____ _____ _____

**If you have any allergies to medications please list the medication and what occurred.**

_____ _____ _____

_____ _____ _____

**List all hospitalizations including the date and reason for the hospitalization.**

_____ _____

_____ _____

**List all prior surgeries, including the date.**

_____ _____

_____ _____

**Do you currently smoke? (circle one)** Yes No

**If yes how many pack/cigarettes do you smoke a day?** _____

**Would you like to discuss quitting today (circle one)?** Yes No

**Are you a former smoker?** Yes No

**If yes what year did you start and what year did you quit?** _____

**Do you drink alcohol?**

Average number of drinks _____ (circle one) Day Week Month

**Are you trying to lose weight or would like help with weight loss (circle one)?** Yes No

**Have you had a shingles vaccine? If so, when?** _____

**Have you had a pneumonia vaccine? If so, when?** _____

**Have you had an influenza vaccine? If so, when?** _____

**Approximately when was your last colonoscopy (who completed the exam)?** _____

**If female, when was your last PAP smear and mammogram? Were they Normal?** _____

**Do you have a family history of colon cancer, breast cancer or ovarian cancer? If so, who and at what age were they diagnosed?** _____

**Have you ever had a bone density scan (if so when) or been told you had osteoporosis?**

_____

**Please circle any of the following that you may have difficulty doing or need help doing:**

| | | | |
|---|---|---|---|
| Using the phone | Transportation | Shopping | Preparing meals |
| Housework | Laundry | taking medication(s) | Hearing |

**Please turn over**

**Screening for risk of falls (circle yes or no for each question):**

| | | |
|---|---|---|
| Have you fallen two or more times in the past twelve months? | Yes | No |
| Have you fallen and hurt yourself since your last visit? | Yes | No |
| Are you afraid of falling due to balance/walking problems? | Yes | No |

**Screening for depression (circle one answer for each question):**

Over the past two weeks have you felt down or hopeless?

No Several days More than half of the days nearly every day

**In the past two weeks have you had little interest or pleasure in doing things?**

No Several days More than half of the days nearly every day

**Circle any of the following symptoms that you've experienced within the past month. Each symptom circled will be evaluated at your annual physical appointment:**

**General/ Constitutional:** Fatigue, Weight gain, Weight loss
**Allergy/Immunology:** Congestion, Sneezing, Watery eyes
**Ophthalmologic:** Blurred vision, Dimished visual acuity, Flashes of light in the visual field, Floaters in the visual field
**ENT:** Decreased hearing, Difficulty swallowing, ringing in the ears, Sore throat, swollen glands
**Endocrine:** Cold intolerance, Excessive sweating, Excessive thirst, Heat intolerance
**Respiratory:** Cough, Shortness of breath with exertion, wheezing
**Breast:** Bloody nipple discharge, Breast pain, Breast swelling, Nipple discharge
**Cardiovascular:** Chest pain, Difficulty lying flat, Fluid accumulation in the legs, irregular heartbeat, palpitation
**Gastrointestinal:** Abdominal pain, Blood in stool, Constipation, Heartburn, Nausea, Vomiting
**Hematology:** Easy bruising, swollen glands
**Women only:** Heavy bleeding during menses, Hot flashes, Irregular menses, Missed periods, Painful intercourse, Painful menses, Vaginal bleeding between periods, Vaginal discharge/itching
**Men only:** Difficulty initiating stream, dribbling after urination, hard testicle, Hernia, Lump in groin, penile discharge, scrotal pain, Scrotal swells.
**Genitourinary:** Blood in urine, frequent urination, Painful urination
**Musculoskeletal:** Painful joints
**Peripheral Vascular:** Pain/cramping in legs after exertion, Painful extremities
**Skin:** Mole(s), rash, History of skin cancer
**Neurologic:** Balance difficulty, Dizziness, Headache, Memory loss, Tingling/Numbness, Tremor
**Psychiatric:** Anxiety, Depressed mood, Difficulty sleeping

**********Please Read**********

We try to be thorough at every office visit to give you the best medical care. Completing this form will help us reach that goal. At your physical exam your medical provider may order additional screening or diagnostic testing based on you medical history and exam. Our staff works very hard and does our best to get any necessary testing covered by your
insurance, however if you have any concerns with billing or with insurance coverage please call our billing department (702-616-9471) and we will do our best to help.

I_____ understand the above and accept financial responsibility for future office visits and diagnostic/screening tests.

**Signature:** _____ **Date:** _____