ANNUAL UPDATE

PLEASE COMPLETE BOTH SIDES

Name: _____ Date: _____

Phone: ( ) _____ Age: _____ Date of last Complete Physical: _____

MEDICAL HISTORY:

1. What major health concerns do we need to discuss today? _____
_____

2. Is there anything that makes it hard for you to take care of your health? _____
_____

3. Since you were here last, have you been in the hospital or the Emergency Room, had surgery, or been in a skilled nursing facility or rehabilitation facility? _____
_____

4. Since you were here last, have you seen any physicians that we did not refer you to? _____

5. Are you allergic to any drugs? Please list.
_____

6. What medicines are you currently taking? Please list the names and doses.

_____ _____ _____
_____ _____ _____
_____ _____ _____

7. Please list any vitamins, supplements or herbal products you are taking:

_____ _____ _____
_____ _____ _____

MEDICAL HISTORY/HEALTH SCREENING:

8. □ Married □ Divorced □ Widowed □ Single □ Separated Date Married: _____
9. Occupation: _____ 10. Hobbies: _____
11. Church affiliation: _____
12. Do you exercise regularly? □ Yes □ No
    What type of exercise? _____ How often? _____
13. Do you smoke? □ Yes □ No How many packs/day? _____ For how many years? _____
14. Do you drink alcohol? (beer, wine, liquor) □ Yes □ No How many drinks/day? _____
15. Do you use recreational drugs? □ Yes □ No If YES, what kind and how often? _____
16. Are you visually impaired? □ Yes □ No If YES, how? _____
17. Do you wear glasses/contacts? □ Yes □ No
18. Do you wear hearing aids or are you hard of hearing? □ Yes □ No
19. List the date of your last:
    Colon exam _____ Tetanus shot _____ Flu shot _____
    Pneumovax shot _____ Bone Density test _____ TB Skin test _____

HAVE ANY OF YOUR BLOOD RELATIVES HAD THE FOLLOWING? IF YES, WHAT RELATIVE?

□ Asthma
□ Cancer
□ Epilepsy/seizures
□ Diabetes/blood sugar problems
□ Goiter/thyroid disease
□ Arthritis
□ Kidney disease
□ Dementia/memory loss
□ Tuberculosis
□ Rheumatic fever
□ High blood pressure
□ Heart problem
□ Migraine headaches
□ Anemia/low blood
□ Immune disease
□ High cholesterol
□ Osteoporosis

→ **OVER** →

COMPLETE PHYSICAL EXAM
MALE ROS

YES	NO	**General**
☐	☐	Weight Loss
☐	☐	Appetite Loss
☐	☐	Fever
☐	☐	Night sweats
☐	☐	Fatigue
☐	☐	Skin
☐	☐	Rash
☐	☐	Change with wart/mole

		HEENT
☐	☐	Blurred Vision
☐	☐	Headache
☐	☐	Double vision
☐	☐	Hearing loss
☐	☐	Ringing in the ears
☐	☐	Vertigo
☐	☐	Nose bleed
☐	☐	Seasonal allergies
☐	☐	Bleeding gums
☐	☐	Hoarseness

		Respiratory
☐	☐	Cough
☐	☐	Decreased exercise tolerance
☐	☐	Snoring
☐	☐	Difficulty breathing
☐	☐	Wheezing

		Breast
☐	☐	Breast mass
☐	☐	Breast pain
☐	☐	Nipple discharge

		Cardiovascular
☐	☐	Chest pain
☐	☐	Difficulty breathing/exert
☐	☐	Irregular heart beat
☐	☐	Elevated blood pressure
☐	☐	Shortness of breath
☐	☐	Swelling of extremities

		Gastrointestinal
☐	☐	Abdominal pain
☐	☐	Change in bowel habits
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Difficulty swallowing
☐	☐	Heartburn
☐	☐	Rectal bleeding

YES	NO	**Male Genitourinary**
☐	☐	Change in Urinary System
☐	☐	Frequency
☐	☐	Blood in Urine
☐	☐	Impotence
☐	☐	Incontinence
☐	☐	Painful Urination
☐	☐	Urinating at night
☐	☐	Sexually Active
☐	☐	Testicular Pain

		Musculoskeletal
☐	☐	Back pain
☐	☐	Joint pain
☐	☐	Joint stiffness
☐	☐	Joint swelling
☐	☐	Muscle pain
☐	☐	Muscle weakness
☐	☐	Osteoporosis
☐	☐	Recent injury

		Neurological
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Headaches
☐	☐	Numbness or Tingling
☐	☐	Seizures
☐	☐	Tremor
☐	☐	Vertigo
☐	☐	Weakness

		Psychiatric
☐	☐	Anxiety
☐	☐	Crying spells
☐	☐	Depression
☐	☐	Mood changes
☐	☐	Insomnia

		Endocrine
☐	☐	Cold intolerance
☐	☐	Excessive thirst
☐	☐	Excessive urination
☐	☐	Heat intolerance

		Hematology
☐	☐	Anemia
☐	☐	Easy bruising
☐	☐	Enlarged lymph nodes