



ANNUAL PHYSICAL DATABASE

Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Age _____ Phone Home _____ Work _____ Cell _____
Occupation _____ Marital Status S M W Sep Div

Briefly list your present medical symptoms _____

Please list your current medications with doses and frequency (*please include over the counter and supplements*)

Please list your medication allergies and reactions

Please list any allergies to pollen, dust, food, or insects

Please list any trips out of the country you have taken in the past year

Vaccination History

Vaccination	Date given or booster	Vaccination	Date given or booster
Polio		Hep A	
Smallpox		Hep B	
Rubella		Pneumonia	
MMR		Meningitis	
Tetanus diphtheria pertussis		Shingles	
Influenza		HPV / Gardasil	

Please list any Significant prior illnesses and ongoing chronic diseases

Please list any hospitalizations or surgeries with the date of occurrence

Last Colonoscopy _____



Name _____

Date _____

FOR WOMEN

Have you noticed a lump in either breast? Y N

Age of first menses _____

Length of cycle _____

Duration of menstrual flow _____

Are your cycles regular? Y N

Date of your last menstrual cycle _____

Do you have bleeding between cycles? Y N

Do you have menstrual discomfort severe enough to stay home? Y N

Do you take medication for this discomfort? Y N

Do you get irritable before periods? Y N

Age at menopause? _____ N/A

Do you have hot flashes? Y N

Have you taken birth control pills or estrogen replacement therapy? Y N

For how long? _____

Do you have a decrease in sexual activity or desire? Y N

Have you noticed vaginal dryness? Y N

Last Mammogram Date _____

Last Bone Density _____

For women please grade the following

How bothered have you been by	Not at all	A little bit	Somewhat	Quite a bit	A great deal	A very great deal
Frequent urination during daytime hours?	0	1	2	3	4	5
An uncomfortable urge to urinate?	0	1	2	3	4	5
A sudden urge to urinate with little or no warning?	0	1	2	3	4	5
Accidental loss of small amounts of urine?	0	1	2	3	4	5
Nighttime urination?	0	1	2	3	4	5
Waking up at night because you had to urinate?	0	1	2	3	4	5
An uncontrollable urge to urinate?	0	1	2	3	4	5
Urine loss associated with a strong desire to urinate?	0	1	2	3	4	5

Please add up your responses to the questions above _____



Name _____

Date _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

- | | | | | | |
|---|---|---|--|---|---|
| • Do you have chest pains ... | | | • Do you usually have severe pains in the arms or legs? | Y | N |
| Exerting yourself? | Y | N | | | |
| Walking up a hill/ stairs? | Y | N | • Are you crippled with severe arthritis? | Y | N |
| After a heavy meal? | Y | N | | | |
| When upset or excited? | Y | N | • Do your joints frequently appear reddish colored? | Y | N |
| • Do you have chest pains or tightness that goes into the shoulders, neck, back, or arms? | Y | N | • Does back pain prevent you from working? | Y | N |
| • Do you get leg cramps when walking? | Y | N | • Are you troubled with a serious bodily disability or deformity? | Y | N |
| • Do you get leg cramps at night? | Y | N | • Do you have any unusual skin growths? | Y | N |
| • Do you have the urge to move your legs, often associated with an uncomfortable sensation? | Y | N | • Have you noticed any change of color or size of any moles or skin growths? | Y | N |
| • Do you get relief from this with movement? | Y | N | • Have you had a recent skin rash? | Y | N |
| • Do your leg symptoms begin or worsen at rest? | Y | N | • Do you have frequent headaches? | Y | N |
| • Do you have abdominal pain/ discomfort... | | | Are they associated with visual trouble? | Y | N |
| After a meal? | | | Are they on one side of the head? | Y | N |
| Brought on by fatty/fried foods? | | | Do they awaken you from sleep? | Y | N |
| That awakens you at night? | Y | N | Do they hurt most in the back of head and neck? | Y | N |
| Relieved by antacids? | Y | N | Do they hurt most in the front? | Y | N |
| Relieved by milk or food? | Y | N | Are they associated with nausea? | Y | N |
| Occurs while eating? | Y | N | Does aspirin/Tylenol! Advil help? | Y | N |
| Occurs immediately after eating? | Y | N | How long do they last? _____ | | |
| Relieved by having a bowel movement? | Y | N | Do they worsen with activity? | Y | N |
| • Do you have poor appetite? | Y | N | • Have you fainted in the past year? | Y | N |
| • Do you often have bleeding gums? | Y | N | • Do you have dizzy spells? | Y | N |
| • Are you frequently nauseated? | Y | N | • Do you have weakness in an arm or leg? | Y | N |
| • Do you often vomit? | Y | N | • Have you had double vision? | Y | N |
| • Do you often have loose stools? | Y | N | • Have you ever had a seizure? | Y | N |
| • Are you often constipated? | Y | N | • Do you have difficulty falling asleep? | Y | N |
| • Are hemorrhoids a problem for you? | Y | N | • Do you have difficulty staying asleep? | Y | N |
| • Have you had a tarry, black bowel movement? | Y | N | • Do you frequently awaken in the morning without apparent cause? | Y | N |
| • Do you often have mucous (phlegm) in your bowel movements? | Y | N | • Do you feel well rested after a night sleep? | Y | N |
| • Do you often belch? | Y | N | • Do you snore loud enough to awaken others? | Y | N |
| • Do you often feel bloated? | Y | N | • Do you have pauses in your breathing while you are asleep? | Y | N |
| • Have you gained weight this year? | Y | N | • Do you have burning when you urinate? | Y | N |
| How much? _____ Lbs. | | | • Do you have loss of bladder control? | Y | N |
| Have you lost weight this year? | Y | N | • Have you seen blood in your urine? | Y | N |
| How much? _____ Lbs. | | | • Have you seen dark (orange, red, brown) urine? | Y | N |
| • Has there been a change in your bowel habits? | Y | N | • Do you have trouble holding your urine? | Y | N |
| • Are your joints often painful? | Y | N | • Do you awaken frequently at night to urinate? | Y | N |
| • Are your joints often swollen? | Y | N | • Have you had a kidney stone? | Y | N |
| • Do your joints often feel stiff? | Y | N | • Do you persistently feel sad or depressed? | Y | N |

