



Patient Name: _____

Date: _____

ANNUAL HISTORY AND PHYSICAL EXAMINATION

The attached forms are to assist me in doing a complete review of your medical condition during your annual comprehensive History and Physical / Preventative Medicine Evaluation.

Take your time completing these forms and provide your best answers to each question provided. Please do not have someone else complete this form for you. Seek their opinions, but only you show complete the form.

Please bring the COMPLETED form with you to your examination.

SOCIAL HISTORY

Have there been any changes in your **employment** status since your last examination yes no

If yes please describe _____

Have there been any changes in your **exercise habits** since your last examination yes no

If yes please describe _____

Have there been any changes in your **relationship** status since your last examination yes no

If yes please describe _____

Have there been any changes in your **tobacco** use since your last examination yes no

If yes please describe _____

Have there been any changes in your **alcohol** use since your last examination yes no

If yes please describe _____

Have there been any changes in your **recreation drug** use since your last examination yes no

If yes please describe _____

Have there been any changes in your **education** since your last examination yes no

If yes please describe _____

Have there been any changes in your **hobbies** since your last examination yes no

If yes please describe _____

Have there been any changes in **pets that live in your home** since your last examination yes no

If yes please describe _____

Have there been any changes in your **financial status** since your last examination yes no

If yes please describe _____

Have there been any changes in your **dietary habits** since your last examination yes no

If yes please describe _____

Have there been any **legal actions against you** since your last examination yes no

If yes please describe _____



Patient Name: _____

CURRENT VITAMINS/ MINERALS / HERBS/ OVER-COUNTER MEDICATIONS

medication/why taken	dose	times a day	

HISTORY OF ANY SURGERIES IN THE PAST YEAR

yes no

If yes please describe _____

COMPLETE SYMPTOM REVIEW

Please check the appropriate box *ONLY if* the following symptoms
have been a regular frequent or recurrent problem for you during the last year

General:

- recent weight loss
- weight gain
- weakness
- fatigue
- fever, chills
- night sweats
- loss of appetite excessive appetite
- sleeping problems
- passing out

Head:

- headaches
- Head injuries
- loss of consciousness
- skull fracture
- brain injuries
- loss of hearing
- ringing in ears
- ear pain
- ear discharge

Eyes:

- blurred vision
- loss of vision
- glasses or contact lenses
- blind spots
- redness
- itching
- tearing
- dryness
- pain
- glaucoma
- double vision
- sensitivity to bright light

- color blindness
- night vision problems
- date of last eye exam

Nose:

- decreased smell
- loss of smell
- abnormal smells
- bloody nose or discharge
- sinusitis
- post nasal drip
- congestion
- sneezing
- broken nose

Mouth:

- bleeding gums
- sore tongue
- grinding teeth
- dental problems
- clenching jaws
- pain
- cold sores or fever blisters

Throat:

- sore throat
- pain
- difficult swallowing
- hoarseness
- change in voice
- lump in throat

Neck:

- stiffness
- soreness
- pain
- Loss of motion
- click or grinding
- Lumps or swelling
- thyroid problems

Lungs:

- cough wet dry
- blood with cough
- wheezing
- short of breath
 - at rest
 - with exertion
- exposure to tuberculosis
- emphysema
- bronchitis.
- Snoring,
- breathing stops at night

Heart:

- chest pain at rest
- chest pain with activity
- Breathing problems at night
- Breathing problems when laying down
- swollen legs, ankles or feet
- heart pounding
- heart fluttering, racing
- skipping heart beat
- history of scarlet fever
- history of rheumatic fever
- High blood pressure



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Blood vessels:

- painful or swollen veins
- leg pain or cramps
 - at rest night walking
- leg ulcers
- blue or cold fingers or toes

Stomach and intestines:

- abdomen or stomach pains
- nausea, vomiting,
- excessive belching
- excessive passing gas
- heartburn
- antacid use,
- difficult swallowing
- painful swallowing
- food sticking
- change in bowel habits
- how often do you have a bowel movement ____
- change in size, shape, color
or frequency of bowel movement
- blood in stools
- blood in toilet paper
- blood on toilet water
- laxative use
- enema use
- diarrhea
- constipation
- clay color stools
- pain in rectum
- rectal spasms
- tea colored urine
- bloating
- history of hepatitis
- loss of control of bowels
- change in weight or appetite
- get full to easy after eating
- pain after eating
- pain before eating
- abdomen cramping

Urine:

- blood in urine
- pus in urine
- burning or painful urination
- foul smelling urine
- urgency to urinate
- how many times do you urinate at night _____
- how many times do you urinate in the daytime _____
- frequent urination
- hesitancy, dribbling, of urine
- discharge
- slow stream
- difficulty starting urination
- difficulty stopping urination
- loss or urine with sneezing
- loss or urine with coughing
- night sweats
- hot flashes

Nerves:

- seizures

- ticks
- spasms
- vertigo
- dizziness
- lightheaded
- tremors
- shakes
- loss of feeling
- abnormal feeling
- tingling
- balance problems or coordination difficulty
- loss of consciousness
- double vision
- headaches
- sensitivity to light
- sensitivity to noise

Glandular:

- tiredness without apparent reason
- heat or cold intolerance
- any change in:
 - hair
 - voice
 - nails
 - breasts
 - testicles
- excessive thirst
- excessive urination

Blood:

- anemia
- easy bruising, easy bleeding
- bleeding gums
- bleeding nose
- history of transfusions
- radiation exposure
- chemical exposure
- lymph node swelling
- tattoos
- body piercing

Moods:

- feeling sad or blue
- mind racing
- feeling restless or nervous
- difficulty with awoken at night
- difficulty fall asleep
- loss of memory
- loss of concentration
- easily distracted
- excessive forgetful
- loss of interest in pursuing hobbies or recreation
- loss of sexual appetite
- excessive sexual appetite
- excessive irritability
- excessive anger
- nervous breakdowns
- excessive worry eating for comfort
- loss of enjoyment in life
- feeling worthless
- feeling helpless
- feeling hopeless
- hearing things that don't make sense
- seeing things that don't make sense

- repeated washing of hands
- repeated checking doors or locks
- panic attacks
- loss of energy
- inability to sit still and rest
- inability to do things that need to be done
- difficulty to get going in the morning
- difficulty to make decisions
- feelings that others are watching you
- feelings that others are after you
- you get special messages from TV or papers
magazines or Radio
- hearing others talk to you in your head
- difficulty overcoming your fears
- history of physical abuse
- history of mental abuse
- history of sexual abuse
- life would be better living somewhere else
- feeling the need to run away or escape
- wondering if you might be better of dead
- sexual problems
- excessive alcohol or drug use
- eating disorders/problems
- sexual problems
- addictions
- learning problems
- marital problems
- relationship problems
- history of injuring self
- history of excessive spending
- history of irresponsible actions
- marital difficulties
- work or coworker problems
- problems with relative and/or children
- financial problems
- received a DUI in the last year
- legal problems in the past year
- concern regarding your alcohol use
- concern regarding your drug use
- go days without need for sleep
- difficulty with mood swings
- excessive irritable

Bones and joints:

- Back or neck pain
- Muscle or joint
 - pain stiffness weakness
 - swollen joints
 - hot joints red joints cramps
 - loss of use

Skin:

- bleeding skin sores
- sores will not heal
- history of severe sun burns
- dry skin
- itching
- rashes
- varicose veins
- change in skin
- nail problem
- change in moles
- new skin growths

