New Pt. Exam/Annual Exam

Name____ Date of Exam_______________________________________

DOB____ Age____

Privacy – May discuss medical issues with:

Name	Relationship	Phone #

Advanced Directives: (ex. Living Will or Durable Power of Attorney for Medicine) Yes☐ No☐

Would you like information: Yes☐ No☐

Allergies **Medication:** None_______ Yes_______ List All

Med	Reaction	Med	Reaction

Environmental ☐ Yes ☐No

Pollen☐ Tree☐ Dust☐ Mold☐ Dog☐ Cat☐ Bee☐

Food: ☐Yes: Please list____ ☐No

Current Medications: Prescription only

Med	Dose	Med	Dose

Non Prescription (Vitamins, supplements, etc.)

Name	Dose	Name	Dose	Name	Dose

When was your last physical: ____

Social History:

Hobbies: (ex. Sport, craft, car, music, art, etc.) List

Smoker ☐No ☐Yes # cigarettes/day_____Cigar_____Pipe_____

Ex-Smoker ☐No ☐Yes When quit_____# yrs. Smoked_____

Alcohol ☐No ☐Yes Amt______# of Drinks_____per day/week/month/year (circle one)

Caffeine ☐No ☐Yes Cola_____Coffee_____Tea_____Chocolate_____Amt/day__________

Recreational Drugs ☐No ☐Tried not current ☐Still Using #_____times per day/week/year (circle one)

List what you use(d):____

Employed ☐ Unemployed☐__________(date) Retired☐__________(date)

Current Job Title____

Duties____

Seat Belt Use ☐100% ☐50% ☐Never

Smoke Detector ☐Yes ☐Functional ☐No

Exercise: (do not include job duties) Regularly ☐Yes x's/week_____ ☐No

What exercise:____

Occasional☐ # of times__________week/month (circle one)

Weight: Current Weight_____ More or less than 1 yr ago (circle one)

Lowest weight past 5 yrs. Approx.__________

Highest weight past 5 yrs. Approx.__________

Surgeries:

Type	Date	Type	Date	Type	Date

Hospital Admission (non-surgical)

Reason	Date	Reason	Date	Reason	Date

Immunizations: Last Tetanus__________approx.

Annual Flu Shot No☐ Yes☐_________approx. date

Pneumonia No☐ Yes☐_________approx. date

Hepatits B series No☐ Yes☐_________approx. date

Other____

Family Hx: Mother: alive age_____ died: what age_____med problem______________________________

Father: alive age_____ died: what age_____med problem______________________________

\# of siblings: alive age_____ died: what age_____med problem______________________________

alive age_____ died: what age_____med problem______________________________

alive age_____ died: what age_____med problem______________________________

alive age_____ died: what age_____med problem______________________________

REVIEW OF SYSTEMS: (List specialist for each area if applies)

General well being__________well________always fatigued_________how long?_______________

Other____

Eyes: Glasses/Contacts No☐Yes☐ Injuries: ☐No☐Yes (describe)____________________________

____

Cataracts: No☐Yes☐ Glaucoma: No☐Yes☐

Name of eye doctor: ________________________________Date of last exam:_______________________

Ears: Injuries ☐No ☐Yes Describe____

Decreased Hearing ☐No ☐Yes Left/Right/Both

Hearing Aid ☐No ☐Yes Left/Right/Both

Ringing(Tinnitus) ☐No ☐Yes Left/Right/Both

Noise Exposure Job ☐No ☐Yes Military ☐No ☐Yes Music ☐No☐Yes

Home ☐No ☐Yes Shoot ☐No ☐Yes Chainsaw☐No☐Yes

Other____

Sinus: Allergies ☐No☐Yes All year___________Seasonal_____________

Hx of sinus infections that required antibiotics: ☐No ☐Yes

Headaches: ☐None ☐Yes How often?_____________________________

Type: Tension HA__________Migraine HA__________Not Dx:________________

Oral: All own teeth ☐Yes☐No Dentures ☐No☐Yes ☐Uppers,☐Lowers,☐Both

Problem swallowing ☐No ☐Yes, describe____

Hoarse voice ☐No ☐Yes, describe____

Last dental Exam:_____________

Neck: Limited Motion ☐No ☐Yes

Pain ☐No ☐Yes

Swelling ☐No ☐Yes

Injuries ☐No ☐Yes,describe____

Endocrine: Hx of Hypertension ☐No☐Yes, when dx:____

Diabetes ☐No☐Yes, when dx:____

Thyroid dis. ☐No☐Yes, when dx:____

☐overactive ☐underactive ☐other________________________________

Respiratory: Short of Breath ☐No ☐Yes

Bronchitis ☐Never☐Yes, how often________________

Pneumonia ☐Never☐Yes, how often________________

Asthma ☐Never☐Yes, when dx:_________________

Asthma symptoms getting better or worse over the years_________________

Require medications ___________how often_____________

Chronic Cough ☐No☐Yes, how long______________

Exposure to (fumes, asbestos, etc)☐No☐Yes, list_______________________________________

Cardiac: History of heart attack☐No☐Yes, when____

History of coronary disease☐No☐Yes, when diagnosed_________________________________

Palpitations ☐No☐Yes

Rheumatoid fever ☐No☐Yes, when____

Chest Pain ☐No☐Yes, when does it occur_________________________________

Heart Valve Dis. ☐No☐Yes, what valve____

Circulation Problem ☐No☐Yes, when______________________

Carotid (neck)___________leg____________

Neurology: Headache ☐No ☐Yes, how often____
Stroke ☐No ☐Yes, when____
Dizzy or unbalanced ☐No ☐Yes, how often___________________________________
Seizures: ☐No ☐Yes, when________________cause_________________________
Weakness of one or more extremities ☐No ☐Yes, which extremities___________________
Fainting spells ☐No ☐Yes

Gastro-intestinal:

☐No problem
☐Hx of peptic ulcer
☐Hx of GERD
☐Hx of gall bladder problem

Constipation often ☐No ☐Yes
Diarrhea often ☐No ☐Yes
Blood in stool ☐No ☐Yes
Indigestion ☐No ☐Yes, how often_______________________

Genitourinary (Genital or Urinary Health):

☐No problem

Hx of renal calculi ☐No ☐Yes, when__________________________
Hx UTI ☐No ☐Yes, how often________________________
Hx blood in urine ☐No ☐Yes, how often________________________
Urine Leakage ☐No ☐Yes, when___________________________
Prostate ☐No ☐Yes, date checked______________________

GYN (female) Specialist
Date of 1st period_____________
Last Menstrual period__________
Are cycles regular ☐No ☐Yes
pregnancies________________
Last pap test________________
Last mammogram________________
History of abnormal gynecological exam ☐No ☐Yes
Vaginal discharge ☐No ☐Yes, ____
Other____

Skin: ☐No problem
Hx of rashes ☐No ☐Yes____
Hx of eczema ☐No ☐Yes____
Hx of psoriasis ☐No ☐Yes____
Hx of skin cancer ☐No ☐Yes____
Other____

Musculoskeletal:

☐No Problem
Joint Pain ☐No ☐Yes, when____
Muscle pain ☐No ☐Yes, when____
Back Problem ☐No ☐Yes, when____
Arthritis ☐No ☐Yes, when____
Broken Bone ☐No ☐Yes, what____
Other____

Signature:________________________________Date:_____________________________