FOXHALL
INTERNISTS, P.C.

3301 New Mexico Avenue, N.W. • Suite 348
Washington, D.C. 20016
Phone 202.362.4467 • Fax 202.362.2303
www.foxhallinternists.com

Mary Restifo, M.D. • Alexander C. Chester, M.D. • Lawrence E. Klein, M.D. • Saulius Naujokaitis, M.D.
Andrew N. Umhau, M.D. • Richard D. Schubert, M.D. • Beth L. P. Ungar, M.D. • Linda L. Yau, M.D.
David M. Hansen, M.D. • Lucy M. McBride, M.D. • John A. Dooley, M.D. • Assil S. Saleh, M.D.

COMPREHENSIVE PHYSICAL EXAMINATION QUESTIONNAIRE

Name_____ **Date**_____

Date of Birth_____ **Age**_____

What medical concerns do you have?

Allergies: Are you allergic to any drugs? (circle) No Yes Please list:_____

Are you allergic to shellfish or iodine? (circle) No Yes Please list:_____

Are you allergic to beestings? (circle) No Yes Please list:_____

Are you allergic to any foods? (circle) No Yes Please list:_____

Medications (List all medications you are taking regularly. Include over the counter, herbal or natural remedies)

Name of medication	Dose (mg)	Frequency (how many times a day)

Medical Illnesses or Conditions (List any chronic conditions which you have been diagnosed to have)

Operations:

Please list any surgery and approximate year

Year	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations:

Other than operations

Year	Reason	Hospital
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Family Medical History	Age	Health (list significant illnesses)	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or Sisters					
Spouse					
Children					

Has any blood relative ever had? (Check if Yes and indicate relationship on the line behind the condition)

____Alzheimer's_____ ____Heart Attack _____ ____Alcoholism_____

____Tuberculosis_____ ____Bleeding Disease_____ ____Mental Disorder_____

____Diabetes_____ ____Stroke_____ ____Allergies_____

____High Blood Pressure_____ ____Seizures_____ ____Asthma_____

____Heart Disease_____ ____Depression_____ ____Cancer_____

Do you have Advanced Directives? No Yes **Have you appointed a health care power of attorney**? No Yes

Name of Health Care Power of Attorney_____**phone #**_____

Immunizations (check if Yes and indicate year of last injection)

____Influenza_____ ____Pneumonia_____ ____Gardasil_____

____Tetanus_____ ____Hepatitis A or B_____ ____Zostavax_____

Transfusions: Have you ever had a blood or plasma transfusion? (circle) No Yes

Preferred Pharmacy_____**phone #**_____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? (circle) No Yes

Name_____ **DOB**_____

Systems Review: Please indicate those items that have been a recurrent or significant change.

Yes	No	Constitutional Symptoms
___	___	Recent significant weight change
___	___	Unusual fatigue or weakness
___	___	Frequent headaches
		Eyes
___	___	Change in vision
___	___	Blurred or double vision
___	___	Eye disease or injury
___	___	Wear glasses or contact lenses?
		Ears/Nose/Mouth/Throat/Neck
___	___	Do you wear hearing aides?
___	___	Hearing loss or ringing in the ears?
___	___	Earaches or drainage?
___	___	Chronic sinus problems or runny nose
___	___	Nosebleeds
___	___	Mouth sores
___	___	Bleeding gums
___	___	Sore throat/hoarseness or voice change
___	___	Lumps or swollen glands in neck
___	___	Difficulty swallowing
___	___	Neck pain or stiffness
		Cardiovascular
___	___	Chest pain or angina
___	___	Palpitations
___	___	Shortness of breath
___	___	Swelling in the feet, ankles or hands
___	___	Waking at night with shortness or breath
		Respiratory
___	___	Chronic or frequent cough
___	___	Coughing or spitting up blood
___	___	Shortness of breath
___	___	Asthma or recurrent wheezing
		Gastrointestinal
___	___	Loss of appetite
___	___	Change in bowel movements
___	___	Nausea or vomiting
___	___	Painful bowel movements/constipation
___	___	Frequent diarrhea
___	___	Rectal bleeding/blood in stool
___	___	Stomach/abdominal pains or heartburn

Yes	No	Genitourinary
___	___	Frequent urination
___	___	Burning or pain on urination
___	___	Blood in urine
___	___	Change in force or strain when urinating
___	___	Incontinence or dribbling or urine
___	___	Sexual difficulties
___	___	Men: Testicular Pain
___	___	Women: Painful periods
___	___	Irregular periods
___	___	Recurrent vaginal discharge

Number of pregnancies (including miscarriages):_____

_____# Deliveries _____# Miscarriages

Method of birth control (if applicable)_____

Menopausal, since when:_____

Date of last menstrual period:_____

Date of last pap smear:_____

Date of last mammogram:_____

Yes	No	Musculoskeletal
___	___	Joint pain (s)
___	___	Joint stiffness/swelling or warmth
___	___	Weakness of muscles or joints
___	___	Muscle pain or recurrent cramps
___	___	Back pain
___	___	Cold hands or feet
___	___	Difficulty in walking
		Integumentary (Skin/Breast)
___	___	Rashes or itching
___	___	Change in skin color or moles
___	___	Change in hair or nails
___	___	Varicose veins
___	___	Breast pain
___	___	Breast lump
___	___	Breast discharge or rash
		Neurological
___	___	Frequent, recurring, or increasing headaches
___	___	Lightheadedness or dizziness
___	___	Convulsions/seizures/spasms
___	___	Numbness or tingling sensations
___	___	Tremors

OVER PLEASE

Yes	No	Psychiatric	Yes	No	Allergic/Immunologic
___	___	Memory loss or confusion	___	___	History of skin reaction or other adverse reaction:
___	___	Nervousness			Describe_____
___	___	Insomnia	___	___	Antibiotic allergy:
___	___	Depression			Describe_____
		Endocrine	___	___	Aspirin allergy
___	___	Hormone problem	___	___	Morphine, Codeine or other narcotic reaction
___	___	Heat or cold intolerance	___	___	Iodine/Shellfish reaction
___	___	Excessive skin dryness	___	___	Beesting reaction
___	___	Excessive thirst or urination	___	___	Food allergies
___	___	Change in glove or hand size	___	___	Latex allergies
		Hematologic/Lymphatic			Dental
___	___	Slow to heal after cuts or wounds	___	___	Dental problems
___	___	Bleeding or bruising tendency	DATE of LAST DENTAL CLEANING:_____		
___	___	Recurrent Anemia	___	___	Take antibiotics before dental cleaning?
___	___	Swelling, warmth or tenderness of veins/history of phlebitis			

COMMENTS:_____

_____

_____

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_____

_____

_____

_____

Patient Signature:_____ **Reviewed by:**_____

Date:_____ **Date:**_____

For clinician use only: