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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)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____ ____Thyroid Disease_____

____Diabetes_____ ____Stroke_____

____Allergies_____ ____High Blood Pressure_____

____Seizures_____ ____Asthma_____

____Heart Disease_____ ____Depression_____

____Cancer_____

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
___	___	Fever, chills, night sweats
		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
___	___	Shortness of breath
___	___	Asthma or recurrent wheezing
		Gastrointestinal
___	___	Loss of appetite
___	___	Change in bowel movements
___	___	Nausea or vomiting
___	___	Rectal bleeding/blood in stool
___	___	Stomach/abdominal pains or heartburn
___	___	Frequent diarrhea

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

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
		Integumentary (Skin/Breast)
___	___	Rashes or itching
___	___	Change in skin color or moles
___	___	Change in hair or nails
___	___	Varicose veins
___	___	Breast pain
___	___	Breast discharge or rash
		Neurological
___	___	Frequent or increasing headaches
___	___	Lightheadedness or dizziness
___	___	Convulsions/seizures
___	___	Numbness or tingling sensations
___	___	Tremors
		Endocrine
___	___	Heat or cold intolerance
___	___	Excessive thirst or urination
___	___	Excessive skin dryness

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