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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)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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)

___COVID vaccines_____ Pneumonia_____ Shingrix_____
____Tetanus_____ ____Hepatitis A or B_____ Influenza_____

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
___	___	Memory loss or confusion
___	___	Nervousness
___	___	Insomnia
___	___	Depression
		Endocrine
___	___	Hormone problem
___	___	Heat or cold intolerance
___	___	Excessive skin dryness
___	___	Excessive thirst or urination
___	___	Change in glove or hand size
		Hematologic/Lymphatic
___	___	Slow to heal after cuts or wounds
___	___	Bleeding or bruising tendency
___	___	Recurrent Anemia
___	___	Swelling, warmth or tenderness of veins/history of phlebitis

Yes	No	Allergic/Immunologic
___	___	History of skin reaction or other adverse reaction:
		Describe_____
___	___	Antibiotic allergy:
		Describe_____
___	___	Aspirin allergy
___	___	Morphine, Codeine or other narcotic reaction
___	___	Iodine/Shellfish reaction
___	___	Beesting reaction
___	___	Food allergies
___	___	Latex allergies
		Dental
___	___	Dental problems
		DATE of LAST DENTAL CLEANING:_____
___	___	Take antibiotics before dental cleaning?

Do you currently smoke cigarettes? Yes No If Yes, How many packs/day_____ for how long?_____

Ever smoked cigarettes? Yes No If Yes, How many packs/day_____ for how long?_____Quit date:_____

Do you currently smoke cigars? Yes No If Yes, How many/day_____for how long?_____

Ever smoke cigars? Yes No If Yes, How many/day_____for how long?_____Quit date:_____

Do you drink alcohol? Yes No If Yes, average number of drinks/day_____

Any caffeine intake? Yes No If Yes, average amount/day_____

Any marijuana use? Yes No If Yes, average amount/day_____

Any other drug use? Yes No If Yes, please list substance and amount/day_____

ANY OTHER COMMENTS:_____

_____

_____

_____

_____

_____

_____

_____

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

Date:_____ **Date:**_____

For clinician use only: