FOXHALL
INTERNISTS, PC

COMPREHENSIVE PHYSICAL EXAMINATION QUESTIONNAIRE

Name_____ **Date**_____

Date of Birth_____ **Age**_____

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

If applicable, name of Health Care Power of Attorney _____ **phone #**_____

Name of Emergency Contact _____ **phone #**_____

What medical concerns do you have? What brings you in today?

Specialists (please list name and number of medical professionals you are actively seeing or have seen recently):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Females Only:

Do you see a gynecologist? If so, please provide name _____; and approx. date of last visit:_____.

Date of last mammogram:_____; Date of last pap smear:_____.

Number of pregnancies (including miscarriages):_____; _____# Deliveries _____# Miscarriages

Date of last menstrual period (or approx. start of menopause): _____.

Males Only:

Do you see a urologist? If so, please provide name _____; and approx. date of last visit: _____.

Are you tracking your PSAs? If yes, please list dates and results of the two most recent tests:

_____; _____.

Family Medical History				
Family Member	**Age**	**Age at death**	**If deceased, cause**	**Health/Significant Illnesses**
Father				
Mother				
Siblings				
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_____ ____Other Mental Disorder _____

____Diabetes_____ ____Stroke_____ ____Allergies_____

____High Blood Pressure_____ ____Seizures_____ ____Asthma_____

____Heart Disease_____ ____Depression_____ ____Cancer_____

Operations:

Please list any surgery and approximate year

Year	**Surgery**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations:

Other than operations

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

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

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Maintenance

Immunizations (check if YES and indicate month and year of last injection)

____Influenza_____ ____Pneumovax_____ ____Zostavax_____

____Tetanus_____ ____Hepatitis A or B_____ ____Shingrix_____

____COVID- 19_(which vaccine and dates): _____

Routine Medical Appointments (if completed, please list last date and provider name)

Skin Check: _____; Eye Exam: _____;

Dental Cleaning**:** _____; Do you require antibiotics for dental appointments?: Yes____ No____.

Colonoscopy (if applicable, please list approx. date and doctor name)**:** _____.

Bone Density (if applicable, please list approx. date and results)**:** _____.

Hearing Test (if applicable, please list approx. date and doctor name)**:** _____.

Other Screening Tests (if applicable, please list other screening tests and results, e.g. CT scan of lungs or ultrasound of aorta):

_____.

Wellness / Habits (circle)**:**

Do you 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? _____
Do you smoke cigars?	Yes	No	If Yes, how many/day_____ for how long? _____
Ever smoked cigars?	Yes	No	If Yes, how many/day_____ for how long? _____
Do you drink alcohol?	Yes	No	If Yes, average number of drinks/week _____
Any caffeine intake?	Yes	No	If Yes, average amount/day _____
Any illicit substance use?	Yes	No	If Yes, please discuss during appointment.

Please describe the type and amount of EXERCISE you achieve weekly: _____

_____

Please describe your typical DIET, including any restrictions (e.g. low carb, vegan) and goals (e.g. weight loss, gain, other):

_____

How many hours of SLEEP do you achieve nightly, on average? _____.

Do you use any sleep aides (e.g. OTC medications, CPAP, sleep hygiene, other)?

_____

Please describe techniques used to manage STRESS (e.g. exercise, meditation, consuming substances [e.g. alcohol]): ___

_____

Please describe your MEMORY in your own words, including how it is (“good” v. “could be better”) and any recent changes:

_____

Please describe your MOOD in your own words, including how it is (“good” v. “could be better”) and any recent changes:

_____

Concerns/Comments:

_____

_____

Systems Review: Please indicate items that have been recurrent or a significant change (feel free to comment and write in margins)**.**

Yes	No	Constitutional Symptoms
___	___	Recent significant weight change
___	___	Unusual fatigue or weakness
		Eyes
___	___	Change in vision, describe: _____
___	___	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
		Cardiovascular
___	___	Chest pain, palpitations, or angina
___	___	Swelling in the feet, ankles or hands
___	___	Waking at night with shortness of breath
		Respiratory
___	___	Chronic or frequent cough
___	___	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
		Psychiatric
___	___	Nervousness/Anxiety
___	___	Insomnia
___	___	Depression
		Endocrine
___	___	Heat or cold intolerance
___	___	Excessive skin dryness
___	___	Excessive thirst or urination

Yes	No	Genitourinary
___	___	Frequent urination
___	___	Burning or pain on urination
___	___	Blood in urine
___	___	Change in force or strain when urinating
___	___	Incontinence or dribbling of urine
___	___	Sexual difficulties
___	___	Men: Testicular Pain
___	___	Women: Painful or irregular periods
___	___	Recurrent vaginal discharge
		Musculoskeletal
___	___	Falls in the last 6 months
___	___	Difficulty in walking
___	___	Joint stiffness/swelling or warmth, specify _____
___	___	Joint/back pain(s), specify _____
___	___	Weakness of muscles or joints
___	___	Muscle pain or recurrent cramps
___	___	Cold hands or feet
		Integumentary (Skin/Breast)
___	___	Rashes or itching
___	___	Change in skin color or moles
___	___	Change in hair or nails
___	___	Breast pain, lump, rash or discharge
		Neurological
___	___	Memory loss or confusion
___	___	Frequent, recurring, or increasing headaches
___	___	Lightheadedness or dizziness
___	___	Convulsions/seizures/spasms
___	___	Numbness or tingling sensations
___	___	Tremors
		Allergic/Immunologic
___	___	History of skin reaction or other adverse reaction:
		Please describe_____.
___	___	Medication allergies (e.g. Antibiotics, Aspirin, Narcotics,
		other): Please describe: _____.
___	___	Other allergies (e.g. Iodine, Shellfish, Beesting, latex,
		other): Please describe: _____.
		Hematologic/Lymphatic
___	___	Slow to heal after cuts or wounds
___	___	Bleeding or bruising tendency

___ ___ Change in glove or hand size ___ ___ Swelling, warmth or tenderness of veins

Do you have any drug allergies?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Preferred Pharmacy_____**phone #**_____

Name of medication	Dose (mg)	Frequency	Indication/Use	Prescriber	Comments
EXAMPLE: Aspirin	81mg	Daily	Cardiac Protection	Dr. John Smith	No side effects
EXAMPLE: Albuterol Inhaler	1 puff	As needed	Asthma	Dr Sue Smith	Rarely take it

Are you having any side effects from these medications? Are there any medications you would like to consider stopping?

How many times a week do you miss a medication? Which one(s)? (The answer is almost never "zero").

Do you have any other questions or concerns about your medications/

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

Date:_____**Date:**_____

For clinician use only: