Health History / Yearly Exam Update

Date _____

Name _____ Date of Birth_____ Age _____

What is the reason for your appointment today? (please mark all that apply)

□ □ physical exam □ □ physical exam with pap smear
□ □ Follow up for □ □ diabetes □ □ high blood pressure □ □ high cholesterol / triglycerides
□ □ depression/anxiety □ asthma □ □ hypothyroidism □ □ osteopenia / osteoporosis
□ GERD other_____
□ □ new problem (please explain) _____

- Since your last physical exam have you had any new diagnosed medical problems? yes no
  If yes, please explain _____
- Since your last physical exam have you had any surgeries? yes no
  If yes, please explain _____
- Since your last physical exam have you had any allergic reaction to medications? yes no
  If yes, please list the medication and the reaction _____
- Do you smoke or chew tobacco? yes no If yes, how much? _____
- Do you drink alcohol on a regular basis? yes no If yes, how much? _____
- Do you have any close relatives with the following conditions? yes no
  Circle any that apply and explain below, please list any additional.

  Breast cancer colon cancer diabetes heart disease
  _____
- Do you exercise on a regular basis? yes no
  If yes, what kind of exercise? _____ How often? _____ times per week
  How long? _____ minutes/time
- Would you say you eat healthy in general? yes no
- Have you received any immunizations since your last visit? yes no

  tetanus pneumonia shingles gardasil (HPV) flu shot other _____
- Please mark if you have had any of the following recently and explain below:

□ Chest pain	□ Incontinence	□ Abdominal pain	□ depression	□ Fever
□ Palpitations/ Heart fluttering	□ Urinary frequency	□ Blood in stool	□ problems sleeping	□ Weight loss □ Weight gain
□ Cough	□ Urinary burning □ Blood in urine	□ Diarrhea □ Constipation	□ anxiety □ suicidal thoughts	□ Muscle aches
□ Shortness of Breath		□ Frequent heartburn > twice a week		□ New or growing moles

□ **None**

If this is your yearly exam: □ Not Applicable

Females

□ Hysterectomy □ Postmenopausal (Any postmenopausal bleeding? yes no)

- First day of your last menstrual period? _____
- What type of birth control do you use? _____
- Are your periods regular? _____ Are they heavy? _____
- Are you sexually active? Yes No Any problems with intercourse? _____

Males

- Any problem with sexual function? yes no
- Any testicular lumps? yes no
- Any penile discharge? yes no

When doing a yearly exam we will also do a follow up appointment for any medical conditions you may have and medications you are prescribed. This will be reflected in your charges. If you would like to only do your physical today please schedule an appointment for your follow up before leaving and notify the nurse that you will do this at a later date.

If you are diabetic: □ Not Applicable

- How often do you check your sugars? _____
- What have your sugars been recently? Highest _____ Lowest _____ Average _____
- When was your last eye exam? _____ Do you any diabetic eye disease ? yes no
- Do you follow a diabetic diet? _____
- Do you look at your feet everyday? yes no Any problems?_____
- Have you seen the diabetes educator? yes no When was the last time? _____

If you have hypertension: □ Not Applicable

- Do you check your blood pressure at home or elsewhere? yes no
  If yes, how often? _____
  Please list your recent readings _____

If you have high cholesterol / triglycerides: □ Not Applicable

- Have you been following a low cholesterol diet? yes no
- If you are on cholesterol medication, have you had any unusual body aches or weakness? yes no

_____ _____ _____ _____

Patient Signature Date Reviewed By Date