COMPLETE PHYSICAL QUESTIONAIRE

Name_____ Date_____

Age_____ Birthdate_____ Date of Last Complete Physical_____

Last menstrual period:_____

Please list current problems or symptoms
1._____
2._____
3._____
4._____

ALLERGIES (list and describe all medication, food, insect, or other allergies or reactions you have had in the past):
1._____ 3._____
2._____ 4._____

PAST MEDICAL HISTORY (please list all medical conditions or problems you have been treated for in the past with dates of treatment)
1._____ 4._____
2._____ 5._____
3._____ 6._____

PAST SURGICAL HISTORY: (list dates and types of all previous surgeries including minor surgeries)
1._____ 4._____
2._____ 5._____
3._____ 6._____

MEDICATIONS: (list all current prescription, nonprescription, herbal and over the counter medications)
1._____ 4._____
2._____ 5._____
3._____ 6._____

SOCIAL HISTORY:
Do you smoke or use any other tobacco products now or in the past? YES NO
If yes, then what product? _____, how many times a day?_____,
for how many years?_____, When did you quit?_____
Do you drink beer, wine or other alcoholic beverages? YES NO
If yes, then what type of product(s)?_____, how many a week?_____.
Do you use recreational drugs? YES NO
If yes, then what drug?_____, how often?_____how many years?_____
How much exercise do you get a week?_____
How much caffeine do you have daily?_____
How often do you wear your seatbelt?_____
Are you on a special diet? If yes then please describe._____
Do you own a firearm?_____
What is your occupation?_____

FAMILY HISTORY:

RELATIVE	PRIOR DISEASES	CURRENT AGE	AGE OF DEATH	CAUSE OF DEATH
MOTHER				
FATHER				
SISTERS				
BROTHERS				
GRANDMOTHER				
GRANDFATHER				
SON				
DAUGHTER				
AUNTS				
UNCLES				

IMMUNIZATIONS:

Did you get routine childhood vaccinations as a child? YES NO
Have you had a tetanus shot in the last 10 years? YES Date?_____ NO
If you travel outside the US, have you had a Hepatitis A vaccine? YES NO
If you are over 65 or have a chronic respiratory disease, have you had a pneumonia vaccine? YES NO
Have you had a flu vaccine this year? YES NO

HAVE YOU HAD OR CURRENTLY HAVE ANY OF THE CONDITIONS LISTED BELOW, PLEASE CIRCLE AND DESCRIBE IN SECTION BELOW (IF ANY FAMILY MEMBER HAS HAD THESE CONDITIONS, PLEASE LIST IN THE FAMILY SECTION)

CANCER
HEART ATTACK
OTHER HEART DISORDERS
HIGH BLOOD PRESSURE
STROKE
DEPRESSION
ANXIETY
DIABETES
EMPHYSEMA
ASTHMA
MIGRAINE HEADACHES
SEIZURES
EYE DISORDERS
HAY FEVER
HEARING PROBLEMS
THYROID DISEASE
GOITER
ARTHRITIS
GOUT
OTHER JOINT DISEASE
TUBERCULOSIS
HIV OR AIDS
HEPATITIS
CHRONIC INFECTIOUS DISEASE
LIVER DISEASE
STOMACH ULCER
COLON/BOWEL DISEASE
GALL BLADDER DISEASE
RECTAL DISEASE
HEMORRHOIDS
ANEMIA
BLOOD DISORDER
KIDNEY DISEASE
KIDNEY STONES
VD/VENERIAL DISEASE
SKIN DISORDER
MENSTRUAL PROBLEMS
BREAST DISEASE
GYNELOGICAL PROBLEMS
PROSTATE TROUBLE
SUICIDE ATTEMPT

Please describe if not already mentioned in the past history

_____

_____

REVIEW OF SYMPTOMS: PLEASE CIRCLE ANY OF THE SYMPTOMS YOU HAVE CURRENTLY AND DESCRIBE BELOW:

GENERAL
Fever
Insomnia
Weight gain
Weight loss
Weakness
Excessive fatigue
Unusual aches or pains
Chills
Night sweats

HEAD/NECK:
Vision loss
Headache
Blurred vision
Eye pan
Ear pain
Hearing loss
Nosebleeds
Sinus problems
Throat pain
Persistent hoarseness
Mouth, tooth, or tongue problems
Goiter
Lumps
Stiffness

SKIN:
Acne
Changing mole
Rash
Yellowing of skin

HEART/CIRCULATION:
Chest pain/pressure
Shortness of Breath
Skipped heart beats
Unusual heart beats
Swelling or edema
Leg cramps

RESPIRATORY:
Chronic cough
Coughing up blood
Wheezing
Short of breath

GASTROINTESTINAL
Chronic diarrhea
Chronic Constipation
Blood in stool
Change in bowel habits
Abdominal Pain
Tarry Bowel Movements
Abdominal swelling
Nausea or Vomiting
Persistent Heartburn

URINARY:
Difficulty passing urine
Blood in urine
Difficulty controlling urine
Waking up to urinate at night
Pain with urination

WOMEN:
Breast Lump:
Breast Discharge
Vaginal Discharge
Change in Menstrual Period
Missed Period
Pain with Periods
Pregnant
Pain with intercourse

MEN:
Penile discharge
Sore on penis
Difficulty with Erections
Testicle Lump
Breast Lump

NEUROMUSCULAR:
Weakness in arm or leg
Dizzy Spells
Fainting Spells
Speech Problems
Tremors
Balance problems
Memory Problems

JOINTS/BONES:
Stiff joints
Swollen joints
Painful joints
Lump on bone/muscle

ENDOCRINE:
Excessive urine frequency
Frequently thirsty
Too warm most of the time
Too cold most of the time

PSYCHOLOGICAL:
Feel generally sad
Suicidal thoughts
Feel depressed
Feel anxious
Feel inferior to others
Loss of interest in hobbies

Please describe:_____