PHYSICAL EXAMINATION

Date:_____

Patients: *Please complete the following to the best of your ability.The Provider will review your answers during your visit.*

Last Name:	First:	Middle:	Date of Birth:
Primary Care Physician:	Office Number:	Last Physical Examination:	
Age:	Sex: ☐M ☐F	Height:	Weight:
Main Reason for Visit:		Referred By:	

Medical & Family History	Self	Family		Self	Family		Self	Family
Seizures			Asthma/COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder Disease/Stones		
Loss of Consciousness			Shortness of Breath			Ulcers		
Stroke			Irregular Heart Rhythm			Colitis		
Glaucoma			Heart Attack or Angina			Constipation		
Thyroid Disorder			Palpitations			Arthritis		
Obesity/Overweight			Heart Valve Disorder			Gout		
Diabetes Mellitus (DM)			Heart Failure (CHF)			Osteopenia or Osteoporisis		
High Blood Sugar			High Blood Pressure			Kidney Disease or Stones		
Abnormal Cholesterol			Rheumatic Fever			Alcohol Abuse		
Insomnia			Tuberculosis			Drug Abuse		
Dementia			HIV			Depression or Anxiety		
			Cancer: (Type:)			Eating Disorder		
Other						Other Psychiatric Illness:		

Surgeries & Hospitalizations	
Reason/Diagnosis	Year

Specialists *(if any)*

Medication Allergies

Name of Medications	Reaction

Prescription Medications

Medication Name	Dose & Frequency	Approx Start Date	Reason for Use

Supplements & Over-The-Counter Medications

Supplement/Medication Name	Dose & Frequency	Approx Start Time	Reason for Use

Screening

TEST	Last Date Done	Results (-) or state findings
Blood Sugar, Cholesterol		
Colonoscopy		
PAP Smear (women)		
Mammogram (women)		
Prostate Exam (men)		
Cardiac Test (EKG, echo, stress, etc)		
Transvaginal Ultrasound		

Female Patients: Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Sleep Disorder				
Anxiety/Nervousness				
Irritability				
Depression/Emotional Swings				
Food Cravings				
Hot Flashes				
Night Sweats				
Vaginal Dryness				
Urine Leakage				
Dry Skin/Wrinkles				
Dry Hair				
Fatigue				
Memory Loss				
Concentration Loss				
Hair Loss				
Loss of Libido/Orgasm				
Muscle Weakness/Loss				
Muscle and Joint pain				
Loss of Pubic Hair				

Male Patients: Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Dry Skin				
Dry Hair				
Sleep Disorder				
Fatigue				
Memory Loss				
Concentration Loss				
Anxiety/Nervousness				
Irritability				
Depression				
Loss of Libido/Orgasm				
Difficulty maintaining erection				
Difficulty achieving erection				
Premature ejaculation				
Muscle Weakness				
Muscle Loss				
Muscle and Joint Pain				
Loss of Masculinity/Confidence/ Aggressiveness				

OB/GYN History (Female Patients)

Last Menstrual Period:	Age at first onset of period:
If still menstruating: cycle _____ days	Circle if (+): Heavy periods, irregularity, spotting, or pain
Are you Pregnant: ☐NO ☐YES Are you trying for a pregnancy: ☐NO ☐YES	Are you breastfeeding: ☐NO ☐YES
Number of pregnancies: Living Children: _____ (Vaginal _____ C-section _____)	Abortions: _____ Miscarriages _____
History of Sexual Abuse: ☐NO ☐YES	

Personal & Social History

Occupation:		Stress Level (0-10):
Marital Status: #Living Children:_____		Do you feel safe in your relationship: ☐YES ☐NO
Use of Alcohol: ☐NO ☐ YES	If YES, what kind:	How many drinks/week:
Tobacco: ☐NO ☐YES	If YES, number of years total _____ Past use-quit date: _____ Cigarettes packs/day _____Cigars/day _____Chew/day _____Pipe/day _____	
Recreational or Street Drug Use: ☐NO ☐YES	If YES, have you ever taken street drugs with a needle: ☐NO ☐YES	
Sexually Active: ☐NO ☐YES	☐ Heterosexual ☐ Bisexual ☐ Homosexual	*Contraception*: Current Method: _____ Past Method _____
Hobbies/Interests:		

Review of Systems

Please check YES to any symptoms that you experience. For any YES answer, please provide a brief description

	YES	If YES, list doctor seen, describe condition and how long
Fever/Chills		
Excess Fatigue		
Weight Loss/Gain		
Enlarged Lymph Nodes		
Frequent Bruising		
Blurry Vision		
Ringing in Ears		
Hearing Difficulty		
Mouth Sores		
Sinus Problems		

REVIEW OF SYSTEMS Con't		
Please check YES to any symptoms that you experience. For any YES answer please provide a brief description		
	YES	If YES, list doctor seen, describe condition and how long
Cardiovascular:		
Chest pain at rest or exercise		
Cold hands/feet		
Swelling of Legs		
Gastrointestinal:		
Constipation		# of bowel movement/day
Diarrhea		
Bloating		
Excessive Belching		
Gas/Acidity		
Blood in Stool		
Thirst: Lack of/too much		# glasses of fluid/day
Genitourinary:		
Pain on Urination		
Cloudy/Bloody Urination		
Urinating too many times		# times per day
Difficulty Urinating		
Loss of Urine		
Musculoskeletal: If YES to any of the following questions, please ask for a PAIN RATING scale.		
Do you see a Chiropractor?		
Any regular body treatment?		
Any regular body massage?		
Back Pain		
Neck Pain		
Shoulder Pain		
Arm Pain		
Hip Pain		
Knee Pain		
Other Pain		
Muscle Point Tenderness		
(Please Describe)		
Skin:		
Acne		
Dry Skin		
Oily Skin		
Loss of Collagen/Firmness		
Wrinkles		
Pigmentation/Scarring		
Any history of skin cancer?		
Do you wear sunblock?		
After sun exposure, do you: ☐BURN ☐Sometimes Burn ☐Rarely Burn ☐Never Burn ☐Tan		
Cellulite		
Emotional:		
Do you see a counselor?		
Do you see a Psychiatrist?		

Depression		

REVIEW OF SYSTEMS Con't Please check YES to any symptoms that you experience. For any YES answer please provide a brief description		
	YES	If YES, list doctor seen, describe condition and how long
Anxiety		
Stress		

Behavioral Style (check one)

_____ Always calm & easy going

_____ Usually calm & easygoing

_____ Sometimes calm with frequent impatience

_____ Seldom calm & persistently driving for advancement

_____ Never calm & have overwhelming ambition

_____ Hard-driving & can never relax

This information will assist us in assessing your particular problem areas and establishing your medical treatment. Thank you for your time and patience in completing this form.

I have answered the above to the best of my abilities.

Patient Signature:_____

Date:

Additional NOTES:

Patient Signature: _____ Date: _____