

COMPREHENSIVE PHYSICAL EXAMINATION PATIENT INSTRUCTIONS

For a comprehensive physical examination, your health care provider will review your medical history, perform a thorough physical examination, and will order age-appropriate diagnostic tests.

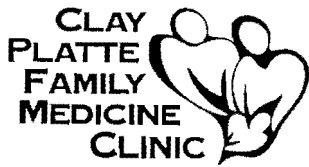
The time required for the comprehensive physical examination will be 1 to 3 hours. Please remember to complete our medical history form and bring it with you for the physical. Include new information regarding medical illnesses in close family members as well.

Specific laboratory tests will be ordered and must be performed on a “fasting” basis in order to obtain accurate results. This means you may have nothing to eat or drink (except water) after midnight on the day the blood will be drawn.

If you are age 40 or older, a treadmill stress test will be performed by your provider. For this procedure, please wear casual clothing and tennis shoes. It is important not to either smoke or drink coffee prior to having this test done.

Finally, please do not hesitate to contact us if you have any questions regarding your comprehensive physical examination.

IMPORTANT: Not every insurance company pays for annual physical examinations. Please contact your insurance company for verification of coverage for this service. Patients are billed for any services which are not reimbursed by insurance.



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Comprehensive Review of Systems

(To be completed by patient *prior* to Complete Physical)

Name: _____ Today's Date: _____ Date of birth: _____ Age: _____ Sex: _____
 Marital Status: _____ No. of children: _____ Occupation: _____ Education level: _____

Please explain any answers in space provided as necessary

<p style="text-align: center;">General</p> <p>General Health: <input type="checkbox"/> poor <input type="checkbox"/> fair <input type="checkbox"/> good <input type="checkbox"/> excellent</p> <p>Exercise per week: _____ Weight loss (past year) _____ Weight gain (past year) _____</p> <p><input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Fevers <input type="checkbox"/> Insomnia <input type="checkbox"/> Snoring <input type="checkbox"/> Apnea (episodes of stopping breathing during sleep)</p>	<p style="text-align: center;">Substance Use</p> <p>Smoking or chewing (amount per day and duration in years): _____</p> <p>Alcohol consumption (avg drinks/week): _____</p> <p>Caffeine (type/quantity per day): _____</p> <p>Recreational/Street drugs: _____</p>	<p style="text-align: center;">Eyes</p> <p>Last eye exam: _____</p> <p><input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Change in vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Redness <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision <input type="checkbox"/> Spot/specks/floaters <input type="checkbox"/> Flashes <input type="checkbox"/> Glaucoma</p>
<p style="text-align: center;">Head/Ears</p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> Past significant head injury <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing of ears <input type="checkbox"/> Earaches or ear pain <input type="checkbox"/> Recurrent ear infections <input type="checkbox"/> Ear drainage <input type="checkbox"/> Hearing aids</p>	<p style="text-align: center;">Nose/Sinus/Throat/Neck</p> <p><input type="checkbox"/> Frequent colds <input type="checkbox"/> Nasal congestion or drainage <input type="checkbox"/> Allergies/hay fever <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Dental problems <input type="checkbox"/> Gum bleeding/pain/swelling <input type="checkbox"/> Dentures <input type="checkbox"/> Tongue or mouth pain./soreness <input type="checkbox"/> Dry mouth <input type="checkbox"/> Mouth or lip sores or ulcers <input type="checkbox"/> Hoarseness <input type="checkbox"/> Neck lumps or masses <input type="checkbox"/> Neck pain or discomfort</p> <p>Last dental exam: _____</p>	<p style="text-align: center;">Respiratory</p> <p>Last chest x-ray or CT scan of chest: _____</p> <p>Date of last Pneumonia vaccine (pneumovax): _____</p> <p><input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Shortness of breath at rest <input type="checkbox"/> Shortness of breath with exercise or exertion <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma or previous history of asthma <input type="checkbox"/> Chronic or recurrent bronchitis <input type="checkbox"/> History of pneumonia <input type="checkbox"/> History of tuberculosis <input type="checkbox"/> Pleurisy</p>
<p style="text-align: center;">Cardiac</p> <p>Previous stress test or heart catheterization: _____</p> <p><input type="checkbox"/> Known heart disease <input type="checkbox"/> Hypertension/High blood pressure <input type="checkbox"/> History of Rheumatic fever <input type="checkbox"/> Heart murmur <input type="checkbox"/> Chest pain <input type="checkbox"/> Chest tightness/pressure/discomfort <input type="checkbox"/> Palpitations <input type="checkbox"/> Fluttering or racing of heart <input type="checkbox"/> Swelling or edema <input type="checkbox"/> Wake from sleep short of breath <input type="checkbox"/> Shortness of breath</p>	<p style="text-align: center;">Gastrointestinal</p> <p>Date of last Colonoscopy: _____</p> <p><input type="checkbox"/> Difficult/painful swallowing <input type="checkbox"/> Heartburn/acid reflux/indigestion <input type="checkbox"/> Change in appetite <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Black or tarry stools <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Change in bowel movements <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abdominal bloating or distension <input type="checkbox"/> Hepatitis <input type="checkbox"/> Gall bladder problems</p>	<p style="text-align: center;">Male Urogenital</p> <p><input type="checkbox"/> Frequent urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Night-time urination <input type="checkbox"/> Urinary hesitancy <input type="checkbox"/> Prostate problems <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Leakage of urine/incontinence <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Penile discharge <input type="checkbox"/> Testicular pain <input type="checkbox"/> Testicular lump or mass <input type="checkbox"/> Penile rashes, sores, or growths <input type="checkbox"/> History of STD <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Loss of sexual interest of libido <input type="checkbox"/> Ejaculatory dysfunction</p>

<p align="center">Female Urogenital</p> <p>Last pap smear: _____ Age when menses started: _____ Number of pregnancies: _____ Number of live births: _____ Current contraception: _____ Age of menopause: _____</p> <p><input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Irregular periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Postmenopausal bleeding <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> History of STD <input type="checkbox"/> Loss of sexual interest/libido <input type="checkbox"/> Urine leakage/incontinence <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Pain with urination <input type="checkbox"/> Kidney stones <input type="checkbox"/> Blood in urine</p>	<p align="center">Breast</p> <p>Date of last Mammogram: _____</p> <p><input type="checkbox"/> Abnormal mammogram <input type="checkbox"/> Breast pain <input type="checkbox"/> Breast lumps or masses <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Breast skin discoloration <input type="checkbox"/> Previous breast biopsy</p> <hr/> <p align="center">Musculoskeletal</p> <p><input type="checkbox"/> Joint pains: If yes, which joints: _____</p> <p><input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Back Pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness</p>	<p align="center">Vascular</p> <p><input type="checkbox"/> Known vascular disease <input type="checkbox"/> Claudication (pain in legs with physical activity that is relieved with rest) <input type="checkbox"/> Leg cramps <input type="checkbox"/> Varicose veins <input type="checkbox"/> Cold extremities <input type="checkbox"/> Poor circulation <input type="checkbox"/> Carotid artery stenosis</p> <hr/> <p align="center">Hematological</p> <p><input type="checkbox"/> Anemia <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Easy/excessive bruising <input type="checkbox"/> Leukemia <input type="checkbox"/> Any known blood disorder <input type="checkbox"/> Enlarged lymph nodes</p>
<p align="center">Neurological</p> <p><input type="checkbox"/> Fainting spells <input type="checkbox"/> Blackout spells <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremor/shakiness <input type="checkbox"/> Numbness/tingling/loss of feeling <input type="checkbox"/> Involuntary movements <input type="checkbox"/> Memory loss <input type="checkbox"/> Confusion <input type="checkbox"/> Temporary loss of vision <input type="checkbox"/> Incoordination <input type="checkbox"/> Gait or balance disturbance</p>	<p align="center">Endocrine</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Previous abnormal blood sugar test <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Frequent urination <input type="checkbox"/> Fatigue</p> <hr/> <p align="center">Psychiatric</p> <p><input type="checkbox"/> During the past month have you often been bothered by feeling down, depressed, or hopeless? <input type="checkbox"/> During the past month, have you been bothered by little interest or pleasure in doing things? <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Obsessive compulsive disorder <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Nervousness <input type="checkbox"/> Panic or anxiety attacks <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Suicidal thoughts</p>	<p align="center">Allergy/Immunologic</p> <p>Date of last Tetanus Shot: _____</p> <p><input type="checkbox"/> Previous serious allergic reaction <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Eczema/atopic dermatitis <input type="checkbox"/> Known allergic reaction to anything in past: _____ <input type="checkbox"/> Hives <input type="checkbox"/> HIV</p> <hr/> <p align="center">Skin</p> <p><input type="checkbox"/> Previous skin cancer: Location: _____ Type of skin cancer: _____ <input type="checkbox"/> Rashes <input type="checkbox"/> Worrisome moles <input type="checkbox"/> Lumps <input type="checkbox"/> Sores <input type="checkbox"/> Itching <input type="checkbox"/> Discoloration</p>

Please List any other health concerns not addressed above or any other information pertinent to your health

Patient Signature: _____ **Date:** ___/___/___

Provider (Physician/Physician assistant/Nurse practitioner) initials: _____