

## 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.



# Clay-Platte Family Medicine Clinic, P.C.

Partnering for Excellence in Health Care  
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## Comprehensive Review of Systems

(To be completed by patient prior to Complete Physical)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please explain any answers in space provided as necessary  
Please complete front and back; sign and date upon completion

### General

- General Health:  poor  
 fair  
 good  
 excellent
- Exercise per week: \_\_\_\_\_
- Weight loss (past year): \_\_\_\_\_
- Weight gain (past year): \_\_\_\_\_
- Fatigue
  - Weakness
  - Fevers
  - Insomnia
  - Snoring
  - Apnea (episodes of stopping breathing while sleeping)

### Head/Ears

- Headaches
- Past significant head injury
- Hearing loss
- Ringing of ears
- Wax buildup in ears
- Earaches or ear pain
- Recurrent ear infections
- Ear drainage
- Hearing aids

### Cardiac

- Previous stress test or heart catheterization (angiogram): \_\_\_\_\_
- Known heart disease
  - Hypertension/High blood pressure
  - History of Rheumatic Fever
  - Heart murmur
  - Chest Pain
  - Chest tightness/pressure/discomfort
  - Palpitations/irregular beating of heart
  - Fluttering or racing of heart
  - Swelling or edema
  - Waking from sleep with shortness of breath
  - Shortness of breath
    - At rest
    - With exertion

### Substance Use

- Smoking or chewing (amount per day and duration in years): \_\_\_\_\_
- Alcohol consumption (avg drinks/week): \_\_\_\_\_
- \_\_\_\_\_
- Have you ever felt you should cut down on your drinking? Yes No*
- Have people annoyed you by criticizing your drinking? Yes No*
- Have you ever felt bad or guilty about your drinking? Yes No*
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? Yes No*
- Caffeine consumption (type/quantity per day): \_\_\_\_\_
- Recreational/Street drug usage): \_\_\_\_\_

### Nose/Sinus/Throat/Neck

- Last dental exam: \_\_\_\_\_
- Frequent colds
- Nasal congestion or drainage
- Nosebleeds
- Chronic sinusitis
- Dental problems
- Gum bleeding/pain/swelling
- Dentures
- Tongue or mouth pain/soreness
- Dry mouth
- Mouth or lip sores or ulcers
- Hoarseness
- Neck lumps or masses
- Neck pain or discomfort

### Gastrointestinal

- Date of last colonoscopy: \_\_\_\_\_
- Difficult/painful swallowing
- Heartburn/acid reflux/indigestion
- Change in appetite
- Nausea and/or vomiting
- Stomach ulcers
- Rectal bleeding
- Black or tarry stools
- Constipation
- Diarrhea
- Change in bowel movements
- Abdominal pain
- Abdominal bloating or distension
- Hepatitis
- Gallbladder problems

### Eyes

- Last eye exam: \_\_\_\_\_
- Glasses
- Contact lenses
- Change in vision
- Eye pain
- Redness
- Excessive tearing
- Double vision
- Blurred vision
- Spots/specks/floaters
- Flashes
- Glaucoma

### Respiratory

- Last chest X-ray or CT scan of chest: \_\_\_\_\_
- Date of previous pneumonia vaccine (Pneumovax): \_\_\_\_\_
- Cough
  - Coughing up blood
  - Shortness of breath
    - At rest
    - With exercise or exertion
  - Wheezing
  - Asthma or previous history of asthma
  - Chronic or recurrent bronchitis
  - History of pneumonia
  - History of tuberculosis or exposure
  - Pleurisy

### Male Urogenital

- Frequent urination
- Painful urination
- Night-time urination
- Urinary hesitancy
- Prostate problems
- Prostate cancer
- Leakage or urine/incontinence
- Blood in urine
- Kidney stones
- Penile discharge
- Testicular pain
- Testicular lump or mass
- Penile rashes, sores, or growths
- History of sexually transmitted disease: \_\_\_\_\_
- Erectile dysfunction
- Loss of sexual interest/decreased libido
- Ejaculatory dysfunction

Please turn over to complete questionnaire → → →

Provider initials: \_\_\_\_\_

## Musculoskeletal

- Joint pains (if yes, which joints): \_\_\_\_\_
- Joint stiffness
- Joint swelling
- Arthritis
- Gout
- Back pain
- Muscle pain
- Muscle weakness
- Muscle cramps

## Endocrine

- Diabetes
- Prediabetes/impaired fasting glucose/hyperinsulinemia
- Previous abnormal blood sugar test
- Thyroid problems
- Heat intolerance
- Cold intolerance
- Excessive thirst
- Excessive sweating
- Frequent urination
- Fatigue

## Neurological

- Fainting spells
- Blackout spells
- Migraine headaches
- Seizures
- Weakness
- Paralysis
- Tremor/shakiness
- Numbness/tingling/loss of feeling(location): \_\_\_\_\_
- Involuntary movements
- Memory loss
- Confusion
- Temporary loss of vision
- Incoordination
- Gait or balance disturbance
- Other symptoms not listed above: \_\_\_\_\_

## Hematological

- Anemia
- Blood transfusions
- Easy/excessive bruising
- Leukemia
- Enlarged lymph nodes
- Any known blood disorder: \_\_\_\_\_

## Breast

- Date of last mammogram: \_\_\_\_\_
- History of abnormal mammogram
- Previous breast biopsy
- Breast pain
- Breast lumps or masses
- Nipple discharge
- Breast skin discoloration

## Female Urogenital

- Date of last Pap smear: \_\_\_\_\_
  - Normal
  - Abnormal
- Age when menses started: \_\_\_\_\_
- Number of pregnancies: \_\_\_\_\_
- Number of live births: \_\_\_\_\_
- Current contraception: \_\_\_\_\_
- Age of Menopause: \_\_\_\_\_
  - Abnormal Pap smear
  - Irregular periods
  - Painful periods
  - Bleeding between periods
  - Pain with intercourse
  - Pelvic pain
  - Postmenopausal bleeding
  - Vaginal discharge
  - History of sexually transmitted disease: \_\_\_\_\_
  - Loss of sexual interest/decreased libido
  - Urine leakage/incontinence
  - Urinary frequency
  - Night-time urination
  - Pain with urination
  - Kidney stones
  - Blood in urine

## Psychiatric

- During the past month have you often been bothered by feeling down, depressed, or hopeless?
- During the past month, have you been bothered by little interest or pleasure in doing things?
- Depression
- Anxiety
- Obsessive compulsive disorder
- ADD/ADHD
- Nervousness
- Panic attacks
- Anxiety attacks
- Bipolar disorder
- Suicidal thoughts
- Sleep disturbance
- Appetite disturbance

## Vascular

- Known vascular disease (Peripheral arterial disease (PAD) or Peripheral vascular disease)
- Claudication (pain in legs with physical activity that is relieved with rest)
- Leg cramps
- Varicose veins
- Swelling or edema of legs/ankles/feet
- Discoloration of lower legs/ankles/feet
- Cold extremities
- Poor circulation
- Carotid artery stenosis

## Allergy/Immunologic

- Date of last tetanus shot: \_\_\_\_\_
- Previous serious allergic reaction: \_\_\_\_\_
- Seasonal allergies
- Asthma
  - Use of daily preventive asthma medication: \_\_\_\_\_
  - How often do you use rescue inhaler (albuterol)? \_\_\_\_\_
- Eczema/atopic dermatitis
- Known allergic reaction to anything in the past: \_\_\_\_\_
- Hives
- HIV
- Would you like HIV testing? Yes No

## Skin

- Previous skin cancer:
  - Location: \_\_\_\_\_
  - Type of cancer: \_\_\_\_\_
- Worrisome moles (location): \_\_\_\_\_
- Lumps
- Sores
- Rashes
- Sores
- Itching
- Discoloration

Please list any other health concerns not addressed above or any other information related to your health:

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

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