PHYSICAL EXAM – FEMALE

Patient Name:_____ Date of Birth:_____ Date of Exam: _____

Allergies: Are you allergic to any medicines? Circle one: Yes No If yes, please complete the following:

Medication	Type of Reaction

Medications: Please list current medicines, inhalers, over the counter medicines, vitamins, and herbals:

Medication	Dose	How often

Surgery/Hospital Stays: Please list ALL operations and overnight hospital stays (not ER visits):

Surgery/Stay: _____ Date: _____

Surgery/Stay: _____ Date: _____

Social History:

Do you smoke? Yes No If yes, how much per day? _____ for how many years? ____
Have you ever smoked? Yes No Quit Date _____
Do you drink alcohol? Yes No If yes, how often? _____ how much? _____
Do you take illicit drugs ("street drugs")? Yes No If yes, which drug? _____
Do you drink caffeinated beverages? Yes No If yes, how often? _____ how much? _____
Describe your eating habits: _____
Describe your exercise routine: _____
What is your sexual preference? Male Female Bisexual
Occupation:

Family History: Please answer the following questions about your family's health:

Diabetes Yes No If yes, who? _____
Asthma Yes No If yes , who? _____
Heart issues Yes No If yes, who? _____
Stroke Yes No If yes, who? _____
Cancer Yes No If yes, who and what type? _____
High blood pressure Yes No If yes, who? _____
High cholesterol Yes No If yes, who? _____
Heart Attack Yes No If yes, who? _____
Depression/Anxiety Yes No If yes, who?_____

Medical History: Have you ever been diagnosed with or do you currently have any of the following symptoms? Please circle all that apply, and when this was an issue for you (date).

HEENT:
Headache
Ear problems
Nose/sinus problems
Throat problems

Musculoskeletal:
Back problems
Joint Pain
Arthritis
Broken bones
Osteoporosis

Endocrine:
Diabetes
Thyroid problems
Tired/sluggish
Excessive thirst

Skin:
Hives
Eczema
Psoriasis
Allergic rash
Atypical moles

Gastrointestinal:
Abdominal Pain
Constipation
Diarrhea
Colitis
Diverticulitis
Heartburn/reflux
Ulcers
Hemorrhoids
Change in Bowel Habits

Genitourinary/GYN:
Bladder infections
Kidney stones
Prostate infections
Ovary problems
Uterine problems
Abnormal Pap smear
Breast lump

Cardiac:
Chest Pain (Angina)
Heart Attack
High Blood Pressure
High Cholesterol
Heart Racing
Palpitations
Heart Failure
Pacemaker
Heart Valve
Rheumatic Fever

Blood/Immune:
Anemia
Blood clot
Jaundice
Lupus
Liver disease

Neurologic:
Seizures/epilepsy
Stroke
Loss of strength
Loss of sensation
Numbness/tingling
Multiple Sclerosis

Respiratory:
Asthma
COPD
Emphysema
Bronchitis
Pneumonia
Pulmonary embolism

Psychologic:
Anxiety
Depression
Bipolar disease
Panic attacks