

Annual Review

Name _____ Date _____ Chart # _____
Primary Care Physician _____ Reason for Visit _____
Pharmacy _____ Phone Number _____

Social History/Health Behaviors:

Occupation _____ Marital Status _____ Age _____
Use of Seat Belt Always Sometimes Never
Number of Servings of Dairy Products or Calcium per day? _____
Caffeine (amount of coffee, tea and colas) _____
Do you do self breast exam? Never Sometimes Monthly
Have you had a mammogram? yes no When _____ Where _____
Exercise yes no Type _____ Number of times/week _____
Number of alcoholic beverages per week: _____ Age at first use: _____
Tobacco products: Never Quit Yes Current packs/day _____ Age at first use _____
Recreational drugs Never Yes Type/Frequency _____
Drug Allergies _____ Food Allergies _____ Latex _____

Personal Medical History: (circle all that apply) Blood clots Heart trouble Osteoporosis Cancer Hepatitis
Pancreatitis Diabetes High blood pressure Thyroid illness Elevated Cholestrol Depression Auto Immune
Current Prescription Medications (Including over the counter medicine and dosage) _____

Nutritional supplements/vitamins/minerals/herbs? _____
Surgeries: _____

Hospitalizations and/or Serious Injuries _____

Family History - circle all that apply (Parents, Grandparents, Brothers, Sisters, Children, Aunts and Uncles)

Blood Clots Heart Trouble Thyroid Illness Cancer High Blood Pressure Diabetes Osteoporosis Aneurysm
Auto immune (lupus, rheumatoid arthritis, multiple sclerosis, Crohn's disease) Elevated Cholesterol Depression
Other _____

The Following Section Will Not Be Released If Records Are Requested

Review of Systems Genital (Please answer the questions in this section that you are comfortable answering)

Number of pregnancies _____ miscarriages _____ abortions _____ living children _____
Did your mother take hormones/DES while pregnant with you? yes no (if born before 1972)
Age at first period _____ Age at menopause _____ Hot Flashes yes no
Do you have pain with your periods? yes no How long does your period last? _____
How often does your period come? (beginning of one to beginning of next) _____
Do you spot or bleed between your periods? yes no Is vaginal dryness a problem? yes no
Are you sexually active? yes no Sexual preference? Male Female Both
Do you have pain with sexual intercourse? yes no Do you bleed after sexual intercourse? yes no
What method of birth control are you using? Birth control pills Depo-Provera Tubal Diaphragm
Vasectomy IUD Natural family planning Condoms Withdrawal Ortho Evra Nuva Ring None
Have you ever had a sexually transmitted disease? yes no If so, what:
Chlamydia Gonorrhea Warts HPV Herpes Syphilis Trichomonas
Number of sexual partners in lifetime _____ in last two years _____ Last Pap _____
Have you ever had an abnormal pap? yes no If so, when? _____
History of abuse? yes no Type: Physical Sexual Emotional

Continue on back

(Please circle any condition(s) that are current and/or ongoing)

Constitutional Systems

Good general health
Recent weight loss or gain

Eyes

Eye disease/injury/problem
Glasses/Contacts

Ear/Nose/Mouth/Throat

Hearing Loss or ringing
Chronic sinus problem
Sore throat or voice change
Swollen glands in neck
Goiter

Cardiovascular

Heart trouble
Chest pain/angina
Irregular or fast heartbeat
Heart murmur
How many pillows do you use to sleep _____
Pain with exercise
Swelling of feet/ankles/hands
Shortness of breath with exercise
Cholesterol test When _____ Result _____

Respiratory

Chronic or frequent cough
Shortness of breath
Asthma or wheezing
Chronic lung disease

Gastrointestinal

Loss of appetite
Nausea or vomiting
Frequent diarrhea
Fecal incontinence
Constipation/painful b.m.'s
Rectal bleeding/blood in stool
Abdominal pain or heartburn
Stomach ulcer
Hemorrhoids/rectal pain
Irritable bowel syndrome
Have you seen a Gastroenterologist?
When? _____

Urinary

Urinating often (>8 times/day)
Burning or painful urination
Blood in urine
Kidney stones
Urine leaking if cannot go immediately
Urine leaking with cough or lifting
Urine leaking with orgasm
Have you seen a Urologist? When? _____
Urinary tract infections

Signature of Patient

Musculoskeletal

Joint pain swelling or stiffness
Weakness of muscles or joints
Back pain
Muscle pain or cramps
Disc Problems
Bone density testing When _____ Where _____

Skin

Rash or itching
Varicose veins
Change in hair or nails
Breast pain/lump
Breast discharge

Neurological

Lightheaded or dizzy
Seizures
Numbness or tingling
Paralysis/Stroke
Head injury (unconscious)
Problems with headaches
Difficulty falling asleep
Difficulty staying asleep
Difficulty getting rest
Sleep Apnea
Snoring

Psychiatric

Memory loss or confusion
Nervousness/Irritability
Depression
Chemical Imbalance
Anxiety/Panic attacks
Difficulty concentrating
Insomnia/poor sleep
Alcohol/Drug dependency

Endocrine

Glandular or hormone problem
Diabetes / low blood sugar
Heat or cold intolerance
Skin becoming dry/oily
Excessive thirst or urination
Ongoing tiredness
Thyroid testing? When? _____ Result _____

Blood/Lymphatic

Anemia
Past transfusion of blood products
Enlarged glands
Auto immune Disease (lupus, rheumatoid arthritis, multiple sclerosis, Crohn's disease)

Vaccinations

Tetanus-diphtheria _____
Hepatitis B _____
Influenza _____
Pneumococcal _____
Measles-Mumps-Rubella _____

Date

Reviewed by _____

Date _____