ANNUAL PHYSICAL FORM **www.familywellnesscntr.com**

NAME _____ **DOB** _____ **Today's Date** _____

LOCAL PHARMACY:
Phone#:
MAIL ORDER PHARMACY:
Address:
City/ ST/Zip:
Phone#:
Member ID #:

MEDICATIONS (including OTC & herbs):	
Name:	Mg. / Dosage

If more medications please write on back of this form.

WOMEN ONLY

Dates of last two Periods _____ _____
Current method of contraception _____
Are you pregnant? Yes No Are you breast feeding? Yes No
Are you trying to get pregnant? Yes No

Number of previous:
Pregnancies _____ Miscarriages _____
Live Births _____ Terminations _____

Age at Menopause _____

Date of Last: PAP Test: _____
Mammogram: _____
Dexascan: _____

MEN ONLY

Do you perform monthly testicular self-exams (TSE)?

☐ Yes ☐ No

Do you have a family history of prostate cancer?

☐ Yes ☐ No

Do you have symptoms of an enlarged prostate? NONE

☐ Urinary dribbling

☐ Reduced flow

☐ Nighttime urination

Date of Last PSA Test: _____

Date of Last Colonoscopy (50+) _____

Adult Immunizations Review – Please list the Date of your Last Immunizations (write N/A if not applicable):
Flu: _____ Pneumonia: _____ Zostavax (Shingles): _____ Tetanus/Diptheria: _____

REVIEW OF SYSTEMS:
Do you now have problems with: (*Mark problems with an "X")* If no medical complaints please circle: NONE

	Present		Present		Present
1. GENERAL:		**5. CARDIOVASCULAR:**		**8. MUSCULOSKELETAL:**	
* **Weight loss, unplanned**		* **Chest Pain**		* **Joint Pain**	
* **Fatigue**		* **Irregular Heart Beat**		* **Joint Swelling**	
* **Memory Loss**		* **Elevated Blood Pressure**		* **Jaw Pain**	
		* **Heart Disease**		**9. NEUROLOGICAL:**	
2. HEENT:		* **Shortness of Breath**		* **Blackouts**	
* **Headache**		* **Swelling of Limbs**		* **Dizziness**	
* **Visual Loss**		**6. GASTROINTESTINAL:**		* **Seizures**	
* **Decreased Hearing**		* **Bloody Stool**		* **Stroke**	
* **Sinus Pain**		* **Constipation**			
* **Hoarseness**		* **Diarrhea**			
* **Sore Throat**		* **Heart Burn**		**10. PSYCHIATRIC:**	
* **Trouble Swallowing**		* **Jaundice**		* **Anxiety**	
		* **Kidney Stones**		* **Depression**	
		* **Nausea**		* **Sleep Issues**	
3. RESPIRATORY:		* **Vomiting**		**11. ENDOCRINOLOGY:**	
* **Cough**				* **Diabetes**	
* **Wheezing**		**7. FEMALE / Genitourinary:**		* **Excessive Thirst**	
		* **Abnormal PAP smear**		* **Excessive Urination**	
4. BREAST:		* **Urinary Complaints**		* **Libido Change**	
* **Breast Mass**		* **Blood in Urine**		**12. HEMATOLOGY:**	
* **Breast Pain**		* **Menstrual Irregularities**		* **Anemia**	
* **Skin Changes**				* **Bleeding Issues**	