Date of Exam: _____

Annual Health Assessment

Name: _____ Date of Birth: _____

Basic Background

Approximate date of last check-up: _____

Please list other physicians, specialists or health care providers, with phone numbers, you have consulted in the past year:

_____

Please list medications you are taking on a regular basis: _____

_____

_____

Please list vitamins and supplements you are taking (please include doses and frequency of use): _____

_____

Please list all known medication or food allergies _____

Any surgeries since your last check-up: _____

Any hospitalizations or ER visits since your last check-up (please specify): _____

_____

Social Background

Please provide an update of the following information since your last annual check-up.

With whom do you currently live?_____

_____

Any change in family structure? _____

Any change in your work situation? _____

Any cigarette, cigar or pipe use? _____

Any alcohol use? _____ If yes, how much do you consume? _____

Any recreational or other drug use? _____

Family Background - Please note any changes in health status of the following:

Mother: _____

Father: _____

Sisters: _____

Brothers: _____

Please note any other disease that is in your family that you are concerned about:
_____

General Review

Over the past year have you lost or gained weight? _____

Are you happy with your current weight? _____

To what do you attribute any change in weight? _____

Are you on a special diet? _____

Do you exercise regularly? _____

Do you have any issues with sleep? _____

Please circle any of the following symptoms that you might be experiencing:

General - fatigue, tiredness, hot flashes, night sweats

Head and Neck - headaches, change in vision, double vision, blurred vision, sinus problems, sore throat, hoarseness, lumps in neck, pain in neck, tingling in hands, weakness in hands

Heart - palpitations, racing, chest pain

Lungs- shortness of breath, cough, wheezing

Abdomen- pain, indigestion, diarrhea, constipation, blood in the stool, incontinence.

Muscular-skeletal system- pain in the shoulders: back, knees, hips, feet, elbows, hands, neck. Swelling in the, shoulder, knees, feet, elbows, hands

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Endocrine- increased thirst, increased nightly urination, increased appetite, change in size of gloves or hat, history of diabetes, thyroid problems, parathyroid problems

Hematologic- easy bleeding, easy bruising

Neurologic- tingling, weakness in arms or legs, trouble with speech, headache, paralysis, memory problems, tremor.

Dermatologic- rash, moles, itching, hair loss, nail discoloration

Mood- depressed, down, anxious, blue, panicky, irritable, stressed out, worrisome.
Are there any other emotional issues that you would like to discuss? _____

Genito-urinary system (for men)- burning urination, frequent urination, blood in the urine, painful urination, difficult urinary stream, incontinence, lumps on groin, lumps on testicles, hernias

Have you consulted with a urologist this year? _____
Have you had a PSA test in the past year? _____
Do you have any concerns about your sexual functioning? _____
Are you concerned about HIV risk? _____ have you ever been tested? _____
Would you like to be tested today? _____

Genito-urinary system (for women)
When was your last menstrual period? _____ is your cycles regular? _____
When was your last of last PAP smear? _____
Do you have any lumps in your breasts? _____
When was your most recent mammogram? _____
Are you concerned about HIV risk? _____ Have you ever been tested? _____
Would you like to be tested today? _____

Travel

Do you have plans to travel outside of the US this year? _____ If yes, please state where you are going, when you are leaving and for how long _____
_____

Please supply approximate dates for the following:

Dental Exam _____ Bone Densitometry _____
Vision Screening _____ Stress Test _____
Hearing Test _____
Chest X-ray _____
Colonoscopy _____
Dermatology Exam _____
Mammogram _____