ANNUAL PHYSICAL FORM (please print name) _____

Do you have now or have you had within the past year: (leave blank if uncertain)

Weakness or paralysis	yes	no	Vomiting	yes	no
Tire easily or weakness	yes	no	Vomited or coughed up blood	yes	no
Recent weight changes	yes	no	Chronic diarrhea	yes	no
Change in appetite	yes	no	Chronic constipation	yes	no
Sensitivity to cold of heat	yes	no	Rectal bleeding	yes	no
Persistent fever	yes	no	Black tarry stools	yes	no
Night sweats or hot flashes	yes	no	Dark urine	yes	no
Skin rash	yes	no	Yellow jaundice	yes	no
Skin trouble or changes	yes	no	Frequent urination (day)	yes	no
Change in nails or hair	yes	no	Frequent urination (night)	yes	no
Headaches	yes	no	Increase in thirst	yes	no
Easy bleeding or bruising	yes	no	Painful urination	yes	no
Double vision	yes	no	Leakage of urine	yes	no
Blurred vision	yes	no	Painful urination	yes	no
Eye pain	yes	no	Difficulty in starting urine	yes	no
Infected eyes	yes	no	Blood in urine	yes	no
Do you wear glasses or contacts	yes	no	Lack of sex drive	yes	no
When was your last eye exam	_____		Hemorrhoids	yes	no
Ringing in ears	yes	no	Backaches	yes	no
Discharge from ears	yes	no	Joint pain or stiffness	yes	no
Ear pain	yes	no	Swollen joints	yes	no
Decrease in hearing	yes	no	Sleeplessness	yes	no
Frequent nose bleeds	yes	no	Seizures	yes	no
Frequent colds	yes	no	Depression	yes	no
Sinus trouble	yes	no	Memory loss	yes	no
Loss of smell	yes	no	Poor coordination	yes	no
Persistent hoarseness	yes	no	Dizziness or fainting spells	yes	no
Sore throat	yes	no	**MEN ONLY**		
Sore gums or tongue	yes	no	Discharge from penis	yes	no
Lump or discharge from breast	yes	no	Pain of lump in testicles	yes	no
Chronic or frequent cough`	yes	no	Impotence	yes	no
Shortness of breath	yes	no	**WOMEN ONLY**		
Bloody sputum	yes	no	Age period began	_____	
Wheezing	yes	no	How many days do periods last	_____	
Chest pain or discomfort	yes	no	How many days between periods	_____	
Purple fingers or lips	yes	no	Is the flow heavy	yes	no
Swelling of hands, feet or ankles	yes	no	Do you bleed or spot between periods	yes	no
Difficulty in breathing	yes	no	Do you have pain or cramps	yes	no
Palpitations or fluttering of the heart	yes	no	Date of last period	_____	
Leg cramps, walking or at night	yes	no	Date of last pelvic exam	_____	
Enlarged veins	yes	no	Date of last mammogram	_____	
Difficultly swallowing	yes	no	Any itching in the vaginal area	yes	no
Heartburn	yes	no	Pain with intercourse	yes	no
Frequent belching	yes	no	Type of birth control used	_____	
Abdominal cramping	yes	no	Number of full term births	_____	
Nausea	yes	no	Number of pre-term births	_____	

Patient signature _____ Date _____