

Annual Medical Survey

Name: _____ Age: _____ Date: _____

Patient Instructions: Welcome again! It is necessary every Annual visit that you complete the following information. It helps us to maintain a thorough review of your health. Please do not leave any blanks. Your answer to every question is important to us. Thank you.

Check All Boxes that Apply:

- Menopausal?
 Prior Hysterectomy?
 Breast Feeding?
 On Hormonal Medicine?
 Cycling? -- First Day of your Last Menstrual Period ____/____/____

LIST ANY MEDICATIONS YOU ARE ON (include over-the-counter medicines/vitamins/herbals)

<u>SINCE YOUR LAST ANNUAL EXAM HAVE YOU HAD:</u>	YES	NO
Normal menstrual cycles? (every 21-35days/bleeding for 3-7days).....	<input type="checkbox"/>	<input type="checkbox"/>
Irregular bleeding? (between cycles/with sexual activity/large clots/heavier flow).....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal vaginal discharge?(normal is clear/white/yellow, without odor or irritation)	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Pain?..... <input type="checkbox"/>		<input type="checkbox"/>
Abdominal Pain?..... <input type="checkbox"/>		<input type="checkbox"/>
Breast Problems? (see BACK page)..... <input type="checkbox"/>		<input type="checkbox"/>
Last Mammogram*: Date ____/____/____ Where? _____		
<small>(*for patients over 40 -- or younger with a strong family history of early-onset disease, or after breast surgery)</small>		
Urinary problems? (see BACK page)		
Do you often leak urine when you cough, sneeze, laugh or exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you leak urine on the way to the bathroom?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you get up more than 2-3 times at night to use the bathroom?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hurt emotionally, physically or sexually?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any New serious illness in your family members?(Birth family)	<input type="checkbox"/>	<input type="checkbox"/>
Have you developed any New medicine allergies?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any <u>NEW</u> medical Problems, Hospitalizations, or Surgeries?...	<input type="checkbox"/>	<input type="checkbox"/>
Describe your Problem: _____		

_____ When did this Problem first begin? _____

Should Today's visit be a Problem Visit *INSTEAD* of an Annual Visit?.....

INSURANCE WAIVER: I understand that if today's appointment starts as an Annual visit & then progresses to a Problem-oriented visit that my physician will be performing TWO separate billable procedures during my appointment time today: (1) the Annual visit & (2) the Problem-oriented visit - that requires evaluation & management outside the scope of the Annual exam. I further understand that both the Annual visit & the Problem-oriented visit will be billed to my insurance company. Should my insurance not pay for the Problem-oriented visit or the Annual visit or both for any reason, contractual or otherwise, I agree to be financially responsible to pay all charges. I also understand that I may schedule another appointment for the Problem oriented visit that my insurance should cover. I certify that I have read & fully understand the conditions set forth.

Signature _____ Print Name _____ Date _____

PLEASE TURN OVER THE PAGE & CHECK THE BOX FOR ANY SYMPTOMS YOU ARE NOW EXPERIENCING

(for Office use only)
 REVIEWED BY _____ Date ____/____/____

Are you currently experiencing any of the following symptoms?

<p>Constitutional:</p> <input type="checkbox"/> Weight Gain or Weight Loss <input type="checkbox"/> Unexplained Fever <input type="checkbox"/> Fatigue	<p>Eyes:</p> <input type="checkbox"/> New Prescription Eye Wear <input type="checkbox"/> Vision Changes
<p>Cardiovascular:</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations	<p>Ears/Nose/Mouth/Throat:</p> <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sore Throat <input type="checkbox"/> Change in Hearing
<p>Respiratory:</p> <input type="checkbox"/> Cough – productive or dry <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing	<p>Gastorintestinal:</p> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea/Vomiting
<p>GenitoUrinary:</p> <input type="checkbox"/> Dark or Bloody Stool <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine	<p>Breast:</p> <input type="checkbox"/> Breast Lump/Mass <input type="checkbox"/> Breast Pain <input type="checkbox"/> Nipple Discharge
<p>Musculoskeletal:</p> <input type="checkbox"/> Joint Pain, Stiffness, Swelling <input type="checkbox"/> Weakness <input type="checkbox"/> Back Pain	<p>Neurologic:</p> <input type="checkbox"/> Numbness <input type="checkbox"/> Memory Loss <input type="checkbox"/> Headache
<p>Skin:</p> <input type="checkbox"/> Skin Nodules <input type="checkbox"/> Changes in moles, freckles <input type="checkbox"/> Changes in Hair – growth, loss, texture	<p>Psychiatric:</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> PMS/Mood Swings
<p>Endocrine/Hormonal:</p> <input type="checkbox"/> Temperature (Hot/Cold) Intolerance <input type="checkbox"/> Excessive Thirst or Urination <input type="checkbox"/> Tremor	<p>Hematologic/Blood/Lymphatic:</p> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Swollen Lymph Glands/Nodes

YES	NO
Do you smoke?..... much?_____	<input type="checkbox"/> <input type="checkbox"/> How
Do you drink alcohol?..... <input type="checkbox"/>	<input type="checkbox"/> How often?_____
Do you do <u>monthly</u> breast self exams?..... <input type="checkbox"/>	<input type="checkbox"/>
Do you exercise?..... Times/week?_____	<input type="checkbox"/>
Do you eat dairy products or take calcium?... <input type="checkbox"/>	<input type="checkbox"/> Servings/day?_____

Thank you for taking the time to answer these questions. Most Insurance companies now require this information to be updated at every visit.