

# PHYSICAL EXAM – FEMALE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

**Allergies:** Are you allergic to any medicines? Circle one: Yes No If yes, please complete the following:

| <u>Medication</u> | <u>Type of Reaction</u> |
|-------------------|-------------------------|
| _____             | _____                   |
| _____             | _____                   |

**Medications:** Please list current medicines, inhalers, over the counter medicines, vitamins, and herbals:

| <u>Medication</u> | <u>Dose</u> | <u>How often</u> |
|-------------------|-------------|------------------|
| _____             | _____       | _____            |
| _____             | _____       | _____            |
| _____             | _____       | _____            |
| _____             | _____       | _____            |
| _____             | _____       | _____            |

**Operations/Hospital Stays:** Please list ALL operations and overnight hospital stays (not ER visits):

Operation/Stay: \_\_\_\_\_ Date: \_\_\_\_\_  
 Operation/Stay: \_\_\_\_\_ Date: \_\_\_\_\_

**Social History:**

Do you smoke? Yes No If yes, how much per day? \_\_\_\_\_ for how many years? \_\_\_\_\_  
 Have you ever smoked? Yes No Quit Date \_\_\_\_\_  
 Do you drink alcohol? Yes No If yes, how often? \_\_\_\_\_ how much? \_\_\_\_\_  
 Do you take illicit drugs ("street drugs")? Yes No If yes, which drug? \_\_\_\_\_  
 Do you drink caffeinated beverages? Yes No If yes, how often? \_\_\_\_\_ how much? \_\_\_\_\_  
 Describe your eating habits: \_\_\_\_\_  
 Describe your exercise routine: \_\_\_\_\_  
 What is your sexual preference? Male Female Bisexual

**Family History:** Please answer the following questions about your family's health:

|              |        |                                  |                     |        |                    |
|--------------|--------|----------------------------------|---------------------|--------|--------------------|
| Diabetes     | Yes No | If yes, who? _____               | High blood pressure | Yes No | If yes, who? _____ |
| Asthma       | Yes No | If yes, who? _____               | High cholesterol    | Yes No | If yes, who? _____ |
| Heart issues | Yes No | If yes, who? _____               | Heart Attack        | Yes No | If yes, who? _____ |
| Stroke       | Yes No | If yes, who? _____               | Depression/Anxiety  | Yes No | If yes, who? _____ |
| Cancer       | Yes No | If yes, who and what type? _____ |                     |        |                    |

**Medical History:** Have you ever been diagnosed with or are currently having any of the following symptoms? Please circle all that apply, and when this was an issue for you (date).

**HEENT:**

- Headache
- Ear problems
- Nose/sinus problems
- Throat problems

**Musculoskeletal:**

- Back problems
- Joint Pain
- Arthritis
- Broken bones
- Osteoporosis

**Endocrine:**

- Diabetes
- Thyroid problems
- Tired/sluggish
- Excessive thirst

**Skin:**

- Hives
- Eczema
- Psoriasis
- Allergic rash

**Gastrointestinal:**

- Abdominal Pain
- Constipation
- Diarrhea
- Colitis
- Diverticulitis
- Heartburn/reflux
- Ulcers
- Hemorrhoids
- Change in Bowel Habits

**Genitourinary/GYN:**

- Bladder infections
- Kidney stones
- Prostate infections
- Ovary problems
- Uterine problems
- Abnormal Pap smear
- Breast lump

**Cardiac:**

- Chest Pain (Angina)
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Heart Racing
- Palpitations
- Heart Failure
- Pacemaker
- Heart Valve
- Rheumatic Fever

**Blood/Immune:**

- Anemia
- Blood clot
- Jaundice
- Lupus
- Liver disease

**Neurologic:**

- Seizures/epilepsy
- Stroke
- Loss of strength
- Loss of sensation
- Numbness/tingling
- Multiple Sclerosis

**Respiratory:**

- Asthma
- COPD
- Emphysema
- Bronchitis
- Pneumonia
- Pulmonary embolism

**Psychologic:**

- Anxiety
- Depression
- Bipolar disease
- Panic attacks