SUSAN SLEEP M.D.
AND ASSOCIATES

Annual Physical Questions. Please Update/Provide Information Since Your Last Physical.

Name *Date of Birth* *Today's Date*

Please describe any medical problems you wish to discuss at this visit:

Past medical history (please list and describe any current or past medical problems not noted above):

Current Medications PLEASE FILL OUT A SEPARATE FORM IN DETAIL LISTING PRESCRIPTION MEDICATION AND SUPPLEMENTS. It is important to fill this out with ALL the information.

Allergic reaction/side effects (Please list any medication/food/supplement and describe the reaction. Ex. Rash))

Social History/Other Information

Ethnicity _____ *Marital status* _____

Occupation _____ *Who lives with you* _____

Do you smoke cigarettes? If so, how much _____ *If quit, when* _____

Have you used any recreational/illicit drugs? _____ *How much alcohol do you drink?* _____

How much caffeine containing beverages do you drink? _____

How much water do you drink? _____

Describe your current exercise activities: _____

Describe your current diet in detail: _____

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Please note the date if you have had any of the following tests at another facility since your last physical:

Colonoscopy _____ Pap smear _____ Rectal exam/ Prostate exam _____

Mammogram _____ Breast exam by health care provider _____ PSA _____

Bone Density scan _____ Eye exam by an Ophthalmologist _____ Dental exam _____

Family History: Please provide any new information which has occurred since your last physical.

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Patient Information Page Two Name: _____ D.O.B. _____

Please check if you are having a problem with any of the following now:

☐ Fever ☐ Chills ☐ Fatigue ☐ Night sweats ☐ Hot flush ☐ Weight loss ☐ Weight gain ☐ Changes in hair ☐ Weakness ☐ Rash
☐ Dry skin ☐ Changes in nails ☐ Itching ☐ New skin growths or changes of concern

_____

_____

_____

☐ Visual disturbance ☐ Double vision ☐ Glaucoma ☐ Cataracts ☐ Eye pain ☐ Hearing loss ☐ Ringing in your ears
☐ Ear pain ☐ Nasal congestion ☐ Nose bleeds ☐ Sinus problems ☐ Problems with your teeth/gums ☐ Hoarseness ☐ Sore throat
☐ Snoring ☐ Neck pain ☐ Swollen "glands" ☐ Difficulty swallowing ☐ Thyroid problems,
Other problems with your eyes, ears, nose, throat, neck:

_____

_____

_____

☐ Breast pain ☐ Breast lumps ☐ Nipple discharge ☐ Other breast problems:_

_____

_____

_____

☐ Cough ☐ Excessive or bloody sputum ☐ Wheezing ☐ Asthma ☐ Bronchitis ☐ Pneumonia
☐ Other problems with your lungs/breathing: _____

☐ Palpitation ☐ Arrhythmia ☐ Edema ☐ Shortness of breath (at rest or with exertion) ☐ Valvular heart disease
☐ Other heart problems: _____

☐ Leg pain/cramps ☐ Phlebitis ☐ Back pain ☐ Neck pain ☐ Hip pain ☐ Groin pain ☐ Knee pain ☐ Arm or shoulder pain ☐ Arthritis
☐ Gout ☐ Other musculoskeletal problems: _____

☐ Heartburn/indigestion ☐ Change in appetite ☐ Nausea or vomiting ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea
☐ Blood in your stool ☐ Black stools ☐ Hepatitis ☐ Irritable bowel ☐ Colitis ☐ Gallstones ☐ Liver disease ☐ Hemorrhoids
☐ Abdominal pain ☐ Food intolerance ☐ History of Ulcer disease ☐ Other intestinal problems

☐ Anemia ☐ Excessive bleeding/bruising ☐ History of blood clots ☐ Other blood disorder: _____
☐ History of blood product transfusion (if so what/when/how much): _____

☐ History of diabetes ☐ Excessive thirst or urination ☐ Intolerance to heat or cold ☐ Anxiety Depression Difficulty sleeping
☐ Other mood disturbance ☐ Fainting ☐ Dizziness ☐ Seizure ☐ Stroke ☐ Tremors ☐ Localized weakness or numbness
☐ Problems with memory ☐ Headache Other neurological problems: _____

☐ Urinary frequency/urgency Incontinence ☐ Urinary tract infection ☐ Blood in urine ☐ Kidney stones ☐ Other problems urinating or change in urination ☐ History of a sexual transmitted disease If so, describe: _____

Problems with sexual desire or function _____

Number of sexual partners in the past few years _____ Men _____ Women _____ Both

Females: Vaginal discharge Pain with intercourse Other problems: _____
If still menstruating: My period occurs every _____ days and lasts for _____ days. Are your periods regular? ☐ Yes ☐ No
Heavy ☐ Yes ☐ No Bleed in between actual period: ☐ Yes ☐ No Severe cramps ☐ Yes ☐ No Check if no longer having menstrual periods ☐ Yes ☐ No # of previous pregnancies _____ Miscarriage/Abortion _____

Males: ☐ Pain in testicles/penis ☐ Penile discharge ☐ Prostate problems Other problems: _____
Other problems not listed above _____

NAME _____ DATE ____/____/____

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Name ______________________________ Date ____/____/____

Medication/ Vitamins/Supplements	DOSE (mg)	TIME taken	REASON TAKING	Dr (who prescribed it)