AIFP
Associates in Family Practice, P.A.

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Complete Physical Exam—Patient Questionnaire

Name: _____ Date of Birth: _____ Sex: _____
Address: _____ Marital Status: _____ Race: _____
_____ Occupation: _____
Home Phone: _____Work: _____Cell: _____

Family History: For each member of your family, follow the line across the page and check the boxes for any illnesses they have had. *Except for spouse, family refers to **blood** relatives.

Family history: For each member of your family check boxes for present state of health and any illnesses they have had. Print names below	Good Health	Poor Health	Deceased — Write in age and cause of death. Include fatal accidents & suicides.	Allergies or Asthma	Anemia	Blood Clotting Issues	Diabetes	Cancer or Tumors	Epilepsy	Glaucoma	Geriatric Disease	Alcoholism	Kidney/Bladder issues	Gastric Ulcers	Psychiatric Issues	Rheumatism/Arthritis	High Blood Pressure	Heart Disease	Dementia	Gout
Father:																				
Mother:																				
Siblings:																				
Spouse:																				
Child:																				
Child:																				
Child:																				
Child:																				
Paternal relatives- (in each box write how many affected with) →																				
Maternal relatives- (in each box write how many affected with) →																				
YOUR health history here. Have you had: →																				

Major hospitalizations: If you have ever been hospitalized for any major illness or operation, write your most recent hospitalizations below. Check this ☐ if you have had more than four such hospitalizations (do not include normal pregnancies)

	Year	Operation or Illness	Name of Hospital	City and State
1st Hospitalization				
2nd Hospitalization				
3rd Hospitalization				
4th Hospitalization				

Date of CPE: _____

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Complete Physical Exam—Patient Questionnaire—continued

: Check the box next to the following additional illnesses or problems that you have now or had in the past.

☐ Eye infections	☐ Pneumonia	☐ Neuralgia/neuritis	☐ Scarlet fever	☐ Mononucleosis
☐ Thyroid disease	☐ Pancreatitis	☐ Tension/anxiety	☐ Measles	☐ STDs
☐ Eczema	☐ Liver disease	☐ Depression	☐ Mumps	☐ Jaundice
☐ Hives or rashes	☐ Diverticulosis	☐ ADHD	☐ Polio	☐ Tuberculosis
☐ Bronchitis	☐ Hernia	☐ Chicken pox	☐ Rheumatic fever	☐ High cholesterol
☐ Emphysema	☐ Hemorrhoids	☐ German measles	☐ Malaria	☐ _____
☐ Hepatitis	☐ Blood transfusion	☐ Drug abuse	☐ Osteoporosis	☐ _____

Tests and immunizations: check the box next to those you have had. Enter the year when the service was performed.

Year performed		Year performed	
☐	___Chest x-ray	☐	___Mammogram
☐	___Kidney x-ray	☐	___Tetanus
☐	___G.I. series	☐	___Polio vaccine
☐	___Colon x-ray	☐	___Typhoid vaccine
☐	___Gallbladder x-ray	☐	___Flu vaccine
☐	___EKG	☐	___MMR
☐	___TB test	☐	___Hepatitis B
☐	___PSA level	☐	___Hepatitis A

Medications: check the box next to any medications you are currently taking or that you are sensitive or allergic to.

Taking	Allergic		Taking	Allergic	
☐	☐	Antibiotics	☐	☐	Hypertension meds
☐	☐	Penicillin	☐	☐	Aspirin
☐	☐	Sulfa	☐	☐	Diet pills
☐	☐	Opiates/codeine	☐	☐	Antacids
☐	☐	Diuretics	☐	☐	Laxatives
☐	☐	Sedatives	☐	☐	Allergy meds
☐	☐	Stimulants	☐	☐	Birth control pills
☐	☐	Caffeine	☐	☐	_____
☐	☐	Demerol	☐	☐	_____

Patient Name:_____ Signature: _____

Date: _____ PCP Name: _____

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Please answer the following questions by checking the box in front of the word YES or NO. Where you are asked for specific information please fill in the blank. If a question does not apply, skip it and go on to the next one. If for any reason you *cannot* or *do not want to* answer a question, put a large * in the area after the NO column (or blank space if applicable). Thank you.

1. Do you have issues with stiff or painful muscles or joints? ☐YES ☐NO
2. Are your joints ever swollen? ☐YES ☐NO
3. Do you have pain in your back or shoulders? ☐YES ☐NO
4. Are your feet often painful? ☐YES ☐NO
5. Are you handicapped in any way? ☐YES ☐NO

6. Do you have any issues with your skin? ☐YES ☐NO
7. Does your skin itch or burn? ☐YES ☐NO
8. Do you have trouble stopping even a small cut from bleeding? ☐YES ☐NO
9. Do you bruise easily? ☐YES ☐NO

10. Do you ever feel faint? ☐YES ☐NO
11. Is any part of your body always numb? ☐YES ☐NO
12. Have you ever had seizures or convulsions? ☐YES ☐NO
13. Has your handwriting changed lately? ☐YES ☐NO
14. Do you have a tendency to shake or tremble? ☐YES ☐NO

15. Are you nervous around strangers? ☐YES ☐NO
16. Do you find it hard to make decisions? ☐YES ☐NO
17. Do you find it hard to concentrate or remember? ☐YES ☐NO
18. Do you usually feel lonely or depressed? ☐YES ☐NO
19. Do you cry often? ☐YES ☐NO
20. Would you say you feel hopeless? ☐YES ☐NO
21. Do you have difficulty relaxing? ☐YES ☐NO
22. Are you troubled by frightening dreams or thoughts? ☐YES ☐NO
23. Do you have a tendency to be shy or sensitive? ☐YES ☐NO
24. Do you have a tendency to worry a lot? ☐YES ☐NO
25. Do you have a strong reaction to criticism? ☐YES ☐NO
26. Do you lose your temper often? ☐YES ☐NO
27. Do little things often annoy you? ☐YES ☐NO
28. Are you stressed by work or family? ☐YES ☐NO
29. Are you experiencing any sexual difficulties? ☐YES ☐NO
30. Have you ever considered committing suicide? ☐YES ☐NO
31. Have you ever desired or sought psychiatric help? ☐YES ☐NO

Patient name:_____

32 Have you gained or lost more than 10 lbs in the last 6 months? ☐YES ☐NO
33 Do you have a tendency to be either too hot or too cold? ☐YES ☐NO
34 Have you recently lost interest in eating? ☐YES ☐NO
35 Do you always seem hungry? ☐YES ☐NO
36 Are you more thirsty than usual? ☐YES ☐NO
37 Is there any swelling in your armpits or groin? ☐YES ☐NO
38 Do you seem to feel exhausted or tired most of the time? ☐YES ☐NO
39 Do you have difficulty falling asleep or staying awake? ☐YES ☐NO
40 Do you exercise *less than* three times a week? ☐YES ☐NO
41 Do you smoke? How much per day?_____ cigarettes/cigar/pipe (circle one) ☐YES ☐NO
42 Do you drink more than one alcoholic drink per day? ☐YES ☐NO
43 Do you drink more than 6 servings of coffee/tea/soda a day? ☐YES ☐NO
44 Are you a regular user of sleep aids/sedatives/pain meds? ☐YES ☐NO
45 Have you ever used heroin, cocaine, LSD, PCP, meth, etc.? ☐YES ☐NO
46 Do you drive a motor vehicle more than25,000 miles per year? ☐YES ☐NO
47 Do you always wear a seatbelt when riding in a car? ☐YES ☐NO
48 List any country outside of the US that you have visited in the last 6 months: ☐YES ☐NO

_____ _____
_____ _____

49 Are you bothered by heartburn? ☐YES ☐NO
50 Do you feel bloated after eating? ☐YES ☐NO
51 Do you have excessive belching? ☐YES ☐NO
52 Do you have discomfort in the pit of your stomach? ☐YES ☐NO
53 Do you become nauseated easily? ☐YES ☐NO
54 Have you ever vomited blood? ☐YES ☐NO
55 Is it difficult or painful to swallow? ☐YES ☐NO
56 Are you constipated more than twice a month? ☐YES ☐NO
57 Are your bowel movements loose for more than a day? ☐YES ☐NO
58 Are your bowel movements either black or bloody? ☐YES ☐NO
59 Are your bowel movements ever grey in color? ☐YES ☐NO
60 Are your bowel moments painful? ☐YES ☐NO
61 Have you ever had bleeding from your rectum? ☐YES ☐NO

62 Do you get up at night frequently to urinate? ☐YES ☐NO
63 Do you urinate more than 5 or 6 times a day? ☐YES ☐NO
64 Do you wet your pants or wet your bed? ☐YES ☐NO
65 Do you have pain or burning when you urinate? ☐YES ☐NO
66 Has your urine ever been brown, black, or bloody? ☐YES ☐NO
67 Do you have difficulty starting your urine flow? ☐YES ☐NO
68 Do you have a feeling that you constantly need to urinate? ☐YES ☐NO

For Men only:
69 Is your urine stream very weak and slow? ☐YES ☐NO
70 Have you ever been told you have prostate problems? ☐YES ☐NO
71 Have you had burning or discharge from your penis? ☐YES ☐NO
72 Are there any swelling or lumps in your testicles? ☐YES ☐NO
73 Do you ever have pain in your testicles? ☐YES ☐NO

Patient name: _____

For Women Only:

74 What was the date of your last menstrual period?_____ ☐YES ☐NO
75 Are you menopausal? ☐YES ☐NO
76 Have you had a hysterectomy? ☐YES ☐NO
77 If you answered yes to the previous 2 questions have you experienced ☐YES ☐NO
any vaginal bleeding since? ☐YES ☐NO
78 Was your last period normal? ☐YES ☐NO
79 Do you have heavy bleeding with your periods? ☐YES ☐NO
80 Have you had any bleeding between periods? ☐YES ☐NO
81 Do you ever have bleeding after intercourse? ☐YES ☐NO
82 Have you had any recent vaginal bleeding or discharge? ☐YES ☐NO
83 Do you do a monthly self breast exam? ☐YES ☐NO
84 Do you have any lumps or pain in your breasts? ☐YES ☐NO
85 Have you ever had any complications with birth control? ☐YES ☐NO
86 When was your last Well Woman Exam and Pap?_____
87 Have you ever been pregnant? ☐YES ☐NO
Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of still births: _____
89 Have you ever had an abortion? ☐YES ☐NO

Both Men and Women:

90 Do you have headaches more than once a week? ☐YES ☐NO
91 Does turning your head quickly cause you pain? ☐YES ☐NO
92 Have you ever had lumps or swelling in your neck? ☐YES ☐NO

93 Do you wear glasses or contacts? ☐YES ☐NO
94 Do you ever have blurred vision? ☐YES ☐NO
95 Is your eyesight becoming worse? ☐YES ☐NO
96 Do you ever have double vision? ☐YES ☐NO
97 Do you ever see colored halos around lights? ☐YES ☐NO
98 Do you have pain in or around your eyes? ☐YES ☐NO
99 Do your eyes itch? ☐YES ☐NO
100 Do your eyes water or cause you to blink a lot of the time? ☐YES ☐NO
101 Have you had any eye issues or concerns in the last 2 years? ☐YES ☐NO
☐YES ☐NO

102 Do you have difficulty hearing? ☐YES ☐NO
103 Do you have frequent earaches? ☐YES ☐NO
104 Do you have any ringing in your ears? ☐YES ☐NO
105 Do you have buzzing or other noises in your ears? ☐YES ☐NO
106 Do you get motion sickness riding in a car or plane? ☐YES ☐NO

107 Do you have any issues with your teeth? ☐YES ☐NO
108 Do you have any sores or swelling in your gums or jaw? ☐YES ☐NO
109 Has your sense of taste changed lately? ☐YES ☐NO
110 Is your tongue sore or sensitive? ☐YES ☐NO
111 Do your nasal passages feel blocked when you don't have a cold? ☐YES ☐NO

Patient Name: _____

112	Does your nose run/drip when you don't have a cold?	☐YES ☐NO
113	Do you ever have sneezing spells?	☐YES ☐NO
114	Do you ever have sinus congestion two or more months in a row?	☐YES ☐NO
115	Does your nose ever bleed for no reason?	☐YES ☐NO
116	Is your throat sore without being sick?	☐YES ☐NO
117	Has a doctor ever told you your tonsils are enlarged?	☐YES ☐NO
118	Is your voice ever hoarse without being sick?	☐YES ☐NO
119	Do you ever wheeze or gasp for breath?	☐YES ☐NO
120	Do you ever have coughing "fits" or attacks?	☐YES ☐NO
121	Do you cough up a lot of mucus or phlegm?	☐YES ☐NO
122	Have you ever coughed up blood?	☐YES ☐NO
123	Do you get bronchitis or chest congestion more than once a month?	☐YES ☐NO
124	Do you sweat more than usual or have night sweats?	☐YES ☐NO
125	Have you ever been told you have high blood pressure?	☐YES ☐NO
126	Have you ever experienced a "pounding" or "racing" heart?	☐YES ☐NO
127	Do you ever get pain or tightness in your chest?	☐YES ☐NO
128	Do you ever experience lightheadedness or dizziness?	☐YES ☐NO
129	Do you get short of breath with little or no exertion?	☐YES ☐NO
130	Do you wake at night short of breath?	☐YES ☐NO
131	Do you have swollen feet or ankles?	☐YES ☐NO
132	Do you use pillows at night to help you breathe while you sleep?	☐YES ☐NO
133	Do you experience cramps in your legs at night or with walking?	☐YES ☐NO
134	Have you ever been told you have a heart murmur?	☐YES ☐NO

Patient Name: _____