Total Family Care
Affiliated with Lawrence Memorial Hospital

Established Patient Physical Questionnaire

Date _____ Name _____
Date of Birth _____ Age _____
Do you have an Advance Directive or other legal, healthcare document?
□ Yes (please provide copy) □ No, but I would like additional information
□ No, and I do not want further information

Drug Allergies _____

Other Allergies _____

CURRENT MEDICATIONS: including over-the-counter and herbal

Medication	Dose	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Are there any of your current medications that you do not understand or have questions about? □Yes □ No
Reactions to current medications? _____
Are there any barriers to you taking your mediations as prescribed? □Yes □No

Pharmacy Name/Location: _____

Reason for today's visit: _____

Other concerns or health-related goals I want to address (may need to occur at future visit): _____
_____

MEDICAL HISTORY UPDATE Since last visit, have you had:
Treatment with other providers? □Yes □No
Surgical procedures? □Yes □No
Hospitalizations? □Yes □No
Emergency Department visits? □Yes □No

When was your last:
Cholesterol check? _____
Eye exam? _____
Colonoscopy? _____
Last PAP? _____
Mammogram? _____
Bone Density/Dexa? _____
Dental Exam? _____
Period? _____ If you do not have periods, when did they stop? _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

FAMILY MEDICAL HISTORY UPDATE
If this was previously reported, please list only new history since last physical; check box if already on file. □
(Indicate new health issues of the following family member, such as cancer, heart disease, high blood pressure, mental illness, allergies, arthritis, diabetes, or any other health concerns.)

Mother: _____ **Brother:** _____

Father: _____ **Sister:** _____

Please complete reverse side

Maternal Grandmother: _____ **Maternal Grandfather: _____**

Paternal Grandmother: _____ **Paternal Grandfather: _____**

SOCIAL HISTORY

Do you smoke? □ Yes □ No If yes, how much? _____
If no, did you ever smoke? □ Yes □ No If yes, how much & when did you quit? _____
How often do you use alcohol? □ Never □ Rarely □ 2-3 times/month □ 2-3 time/weeks □ Daily
Average number of drinks per episode: _____
Who lives at home with you? _____
Concerns about abuse/neglect in your home? _____
□ Single □ Married □ Divorced □ Widowed □ Single but in long term relationship
Number of children? _____ Religious restrictions? _____
Do you use any illicit/recreational drugs? □ Yes □ No If yes, what kind? _____
Do you exercise? □ Yes □ No If yes, how often & what type? _____
What is your current occupation? _____
Are you currently sexually active? □ Yes □ No New partners since last exam? □ Yes □ No
Are you interested in getting tested for sexually transmitted diseases? □ Yes □ No
Do you have a history of sexually transmitted disease? □ Yes □ No Abnormal Pap? □ Yes □ No _____
Do you have a history of sexual abuse? □ Yes □ No
Special diet: _____
Caffeine intake: _____
Do you use seatbelts? □ Yes □ No If motorcycle rider, do your wear a helmet? □ Yes □ No □ N/A
Current sources of stress in your life: _____

Please circle if you are having any of the following problems recently:
Constitutional: [Fever] [Chills] [Sweats][Weakness] [Fatigue] [Decreased Activity]
Eyes: [Recent visual problems] [Discharge] [blurring] [Double Vision] [Visual disturbances]
ENT: [Decreased hearing] [Ear pain] [Nasal congestion] [Sore throat]
Respiratory: [Shortness of breath] [Cough] [Sputum production] [Coughing up blood] [Wheezing] [Apnea]
Cardiovascular: [Chest pain] [Palpitations][Slow heart rate] [Fast heart rate] [Swelling] [Fainting]
Gastrointestinal: [Nausea] [Vomiting] [Diarrhea] [Constipation] [Heartburn] [Abdominal pain] [Vomiting blood]
Genitourinary: [Pain with urination] [Blood in urine] [Change in urine stream] [Urethral discharge] [Lesions]
Gynecologic: [Painful periods] [Hot flashes] [Intermenstrual bleeding]
Hema/Lymph: [Bruising tendency] [Bleeding tendency] [Swollen lymph glands]
Endocrine: [Excessive thirst] [Frequent urination] [Cold intolerance] [Heat intolerance] [Excessive hunger]
Immunologic: [Immunocompromised] [Recurrent fevers] [Recurrent infections] [General discomfort]
Musculoskeletal: [Back pain] [Neck pain] [Joint pain] [Muscle pain] [Lower leg pain] [Decreased range of motion] [Trauma]
Skin: [Rash] [Itching] [Abrasions] [Sores] [Burns] [Dryness] [Broken blood vessels] [Skin lesion] [Raised scar]
Neurologic: [Abnormal balance] [Confusion] [Numbness] [Tingling] [Headache]
Psych: [Anxiety] [Depression] [Mania] [Suicidal] [Delusional] [Hallucinations]
Other items not mentioned above: _____

VACCINATIONS

Have you had any vaccinations since your last physical?

□ Tetanus Date: _____
□ Pneumonia Date: _____
□ Shingles Date: _____
□ HPV (series of 3) Date: _____
□ Hepatitis A (series of 2) Date: _____
□ Hepatitis B (series of 3) Date: _____
□ Meningitis Date: _____
□ Chicken pox (varicella) Date: _____
□Had the disease Date: _____
□ Influenza Date: _____

We are happy to request medical records from other medical providers for documentation purposes.