Scottsdale Family Health

Established Patient- Physical Form

Patient Name _____ Date of Birth _____

What concerns do you have today?

Please list pharmacy you would like us to use for your medications.

Pharmacy	**Phone Number**	**Fax Number**

Since your last visit:

1. Have you been diagnosed with any new medical conditions? ___Yes ___No

If Yes (give details)

2. Have you undergone any recent surgical procedures? ___Yes ___No

If Yes (give details)

3. Have you had any medication, vitamin or supplement changes? ___Yes ___No

4. Has there been any change in your family history? ___Yes ___No

If Yes (give details)

5. Do you currently smoke or use tobacco products? ___Yes ___No

6. Do you drink alcohol? ___Yes ___No

If yes, how many drinks _____ in a [day, week or month]

7. Do you have any risk for sexually transmitted disease (multiple partners, unprotected intercourse, etc)? ___Yes ___No

8. **Current activity level** (check which describes most accurately):

__Not much (sedentary) __Minimal __Active, but No Exercise __Some Exercise
__Regular Exercise :_____

9. **Please describe your current diet** (check all that apply):

__ Well-balanced, controlled portions ___ Unbalanced ___ Excessive Portions
__ Low Salt __ Low Fat ___ Low Carbs _____ Restricted calories (_____ cal/day)
___ Other: _____

10. **End of Life Planning**

Do you have a written advance directive, living will, power of attorney, or end of life planning (such as resuscitation desire)? ___Yes ___No
If yes, is this in your chart? ___Yes ___No ___Unsure

Do you wish to discuss any end of life issues during this exam? ___Yes ___No

11. Last Eye Exam Date _____

12. Last Dental Exam Date _____

Immunizations:

Please list the last time you were vaccinated for the following:

Name	Last Date of Vaccination
Pneumonia Shot (Pneumovax)	
Flu Shot (Influeza Vaccine)	
Shingles Vaccine (Zostavax)	
Tetanus Shot (DT, Td, Tdap)	

Preventative Testing:

Name	Date Last Done
Colonoscopy	
Electrocardiogram (EKG)	
Cardiac Stress Testing	
Prostate Testing (males only)	
Mammogram (females only)	
Pelvic Exam/PAP smear	
DEXA/Bone Scan	

Medication List: (please list all medications you are taking ***OR ATTACH LIST***)

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

[Note : include inhalers, nasal sprays, etc]

Allergy List: (please list all allergies you have to medications ***OR ATTACH LIST***)

Medication Allergy	Reaction

Provider List: (please list any other doctors/specialists you are seeing ***OR ATTACH LIST***)

Doctor	Specialty

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Check all that apply:

General- ☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Weakness ☐ Trouble sleeping

Skin- ☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness☐ Color changes ☐ Hair and nail changes

Head- ☐ Headache ☐ Head injury

Ears- ☐ Decreased hearing ☐ Ringing in ears (tinnitus) ☐ Earache☐ Drainage

Eyes- ☐ Vision Changes ☐ Glasses or contacts ☐ Pain ☐ Redness ☐ Blurry or double vision ☐ Flashing lights ☐ Glaucoma ☐ Cataracts

Nose- ☐ Stuffiness ☐ Discharge ☐ Itching ☐ Nosebleeds☐ Sinus pain

Throat- ☐ Teeth issues ☐ Gums ☐ Bleeding☐ Dentures ☐ Sore tongue ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush ☐ Non-healing sores

Neck- ☐ Lumps ☐ Swollen glands ☐ Pain☐ Stiffness

Breasts- ☐ Lumps ☐ Pain ☐ Discharge

Respiratory-☐ Cough ☐ Sputum☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing ☐ Painful breathing

Cardiovascular-☐ Chest pain or discomfort ☐ Tightness ☐ Palpitations☐ Shortness of breath with activity ☐ Swelling in legs ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal- ☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea ☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea ☐Yellow eyes or skin

Urinary- ☐ Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine(hematuria) ☐ Incontinence ☐ Change in urinary strength

Genital-

Males Only -☐ Pain with sex ☐ Hernia ☐ Penile discharge ☐ Sores ☐ Masses or pain ☐ Erectile dysfunction ☐ STD's

Females Only- ☐ Pain with sex ☐ Vaginal dryness ☐ Hot flashes ☐ Vaginal discharge ☐ Itching or rash ☐ STD's

Vascular- ☐ Calf pain with walking (Claudication) ☐ Leg cramping

Musculoskeletal- ☐ Muscle or joint pain ☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints ☐ Trauma

Neurologic-☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness ☐ Numbness ☐ Tingling☐ Tremor

Hematologic- ☐ Ease of bruising ☐ Ease of bleeding

Endocrine- ☐ Head or cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst

Psychiatric- ☐ Nervousness ☐ Depression ☐ Memory loss ☐ Stress