

UPDATE FOR ANNUAL PHYSICAL

DATE OF LAST PHYSICAL _____

NAME _____ DOB _____ AGE _____ TODAY'S DATE _____

THINGS YOU WOULD LIKE TO DISCUSS DURING THIS VISIT:

- 1. _____
- 2. _____
- 3. _____

CURRENT MEDICATIONS INCLUDING OVER THE COUNTER:

DRUG NAME	STRENGTH	HOW OFTEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

HAVE YOU HAD ANY IMMUNIZATIONS SINCE YOUR LAST PHYSICAL? LIST BELOW:

IN THE PAST 12 MONTHS, OR SINCE YOUR LAST PHYSICAL, HAVE YOU HAD:

	YES	NO	DATE	DR. NAME OR LOCATION IF KNOWN
GYN EXAM	_____	_____	_____	_____
EYE EXAM	_____	_____	_____	_____
DENTAL	_____	_____	_____	_____
COLONOSCOPY	_____	_____	_____	_____
BONE DENSITY TEST	_____	_____	_____	_____
PSA TEST	_____	_____	_____	_____
MAMMOGRAM	_____	_____	_____	_____
STRESS TEST	_____	_____	_____	_____
EKG	_____	_____	_____	_____
CHEST XRAY	_____	_____	_____	_____

LIST ANY NEW MEDICATION OR FOOD ALLERGIES SINCE LAST PHYSICAL

HAVE YOU HAD ANY SURGERIES SINCE LAST PHYSICAL? (IF YES, WHAT WAS THE SURGERY?)

HAVE YOU HAD ANY NEW DIAGNOSES SINCE LAST PHYSICAL? _____

WHAT IS YOUR CURRENT FITNESS ROUTINE? _____

DO YOU SMOKE? _____ **IF YES, # DAILY** _____ **DO YOU DRINK?** _____ **IF YES, # DAILY** _____