

**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** \_\_\_\_\_