Annual Physical – Name:_____ **Date:**_____

Social History

Married □	Single □	Widowed □	
Employed	Yes □ No □	If yes, Occupation _____	
Tobacco	Yes □ No □	If yes: How many Cigarettes/day _____	How many years_____
Alcohol	Yes □ No □		
	If yes, how many drinks/day _____	What type of Alcohol: Beer Wine	Other _____
	Do you feel you need to cut down on your drinking?	Yes □ No □	
	Do you feel annoyed by criticisms of your drinking?	Yes □ No □	
	Do you feel guilty about your drinking?	Yes □ No □	
	Have you ever had a morning drink for an eye opener?	Yes □ No □	
Marijuana	Yes □ No □		

Past Medical History/ Major Events

Surgery

Type of Surgery	Date	
1		
2		
3		
4		

Hospitalizations

Diagnosis	Date
1	
2	
3	
4	

Current Medical Diagnosis

1	3
2	4
5	6
7	8

Current Medications

1	5
2	6
3	7
4	8

Family History

	Diabetes	Hypertension	Heart Disease	High Cholesterol	Cancer
Father					
Mother					
Sibling					
Grandfather					
Grandmother					

Preventive Care (*Please put date*)

Annual Physical		Pap Smear (women only)		PSA (men only)
Mammogram	Colonoscopy	Dexa Scan	Tetanus/Tdap	Hep B
Pneumovax 23	Prevnar 13	Shingles/Zoster		Tuberculosis/PPD
Gardasil				

Nutrition

3 Meals/day	Yes □	No □	
Exercise	Yes □	No □	If yes, what type _____ number of times_____
Drink Water	Yes □	No □	If yes, how much per day _____

Safety Questions

Do you wear your seatbelts?	Yes □	No □
Are there working fire alarms in the home?	Yes □	No □
Are there firearms (guns) in the home?	Yes □	No □
Do you feel safe at home?	Yes □	No □
Are you experiencing any abuse, physical or emotional?	Yes □	No □