

# COMPREHENSIVE PHYSICAL EXAMINATION

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Medical

Overnight hospitalizations - medical or surgical *(Please include year)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicines you are currently taking including vitamins & nutritional supplements *(Please include dosage)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: Please list medication allergies and reaction. Include any allergy to Penicillin, Sulfa, iodine, seafood or dyes.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any past or current medical problems such as diabetes, high blood pressure, heart attacks, skin problems, etc. Write the name of the physician, health practitioner or medical facility treating you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health Maintenance

Please list the last year of your last:

Pap smear \_\_\_\_\_ Mammogram \_\_\_\_\_ Flexible sigmoidoscopy \_\_\_\_\_

Cholesterol test \_\_\_\_\_ Stool test for blood \_\_\_\_\_ Colonoscopy \_\_\_\_\_

Bone density test \_\_\_\_\_

Immunizations / Vaccinations – Please list year of last:

Tetanus \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Flu vaccine \_\_\_\_\_ Pneumovax \_\_\_\_\_

## Family History

Please list which family members have had the following illnesses:

Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Diabetes \_\_\_\_\_ Heart Attacks \_\_\_\_\_

High Cholesterol \_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_

Breast Cancer \_\_\_\_\_ Seizures \_\_\_\_\_

Asthma \_\_\_\_\_ Strokes \_\_\_\_\_

Osteoporosis \_\_\_\_\_

## Social History

Occupation: \_\_\_\_\_

Tobacco Use: How much? \_\_\_\_\_ Number of years? \_\_\_\_\_

Caffeine Use: How much? \_\_\_\_\_

How much alcohol (including beer) do you drink in a week? \_\_\_\_\_

Are you married, single, divorced, other? \_\_\_\_\_

Please list the people currently living with you: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you exercise? \_\_\_\_\_ How many times a week? \_\_\_\_\_

## Safety

Do you wear a seat belt? \_\_\_\_\_ Do you own firearms? \_\_\_\_\_

Do you have smoke alarms in your home? \_\_\_\_\_ Carbon monoxide detectors? \_\_\_\_\_

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Date of Birth: \_\_\_\_\_

## Symptom Review

On this page, please check any symptoms that you **CURRENTLY** have with a **C** and any symptoms that have been a problem in the **PAST** with a **P**.

### General

Fevers \_\_\_\_\_  
Weight loss/gain \_\_\_\_\_

### Eyes

Vision change \_\_\_\_\_  
Double vision \_\_\_\_\_  
Eye pain \_\_\_\_\_  
Yellow eye \_\_\_\_\_

### Ear, Nose, Throat

Hearing loss \_\_\_\_\_  
Sinus pain \_\_\_\_\_  
Nose bleeds \_\_\_\_\_  
Lump in mouth \_\_\_\_\_  
Seasonal allergies \_\_\_\_\_

### Cardiovascular

Chest pain \_\_\_\_\_  
Palpitations \_\_\_\_\_  
Swelling in legs \_\_\_\_\_  
Irregular heart beat \_\_\_\_\_  
Abnormal EKG \_\_\_\_\_

### Respiratory

Shortness of breath \_\_\_\_\_  
Wheezing \_\_\_\_\_  
Coughing \_\_\_\_\_  
Coughing up blood \_\_\_\_\_  
Pneumonia \_\_\_\_\_

### Gastrointestinal

Trouble swallowing \_\_\_\_\_  
Stomach pain \_\_\_\_\_  
Ulcer \_\_\_\_\_  
Constipation \_\_\_\_\_  
Diarrhea \_\_\_\_\_  
Hemorrhoids \_\_\_\_\_  
Blood in stool \_\_\_\_\_

### Musculoskeletal

Joint pain \_\_\_\_\_  
Muscle weakness \_\_\_\_\_  
Back pain \_\_\_\_\_  
Trouble walking \_\_\_\_\_

### Genitourinary

Kidney stones \_\_\_\_\_  
Blood in urine \_\_\_\_\_  
Urinary tract infections \_\_\_\_\_  
Urinary leakage \_\_\_\_\_  
Increased frequency \_\_\_\_\_

### Skin

Rash \_\_\_\_\_  
Growths \_\_\_\_\_  
Change in mole \_\_\_\_\_  
Warts \_\_\_\_\_

### Neurologic

Headaches \_\_\_\_\_  
Seizure \_\_\_\_\_  
Numbness \_\_\_\_\_  
Stroke \_\_\_\_\_  
Visual Abnormalities \_\_\_\_\_

### Psych

Trouble sleeping \_\_\_\_\_  
Trouble concentrating \_\_\_\_\_  
Depression \_\_\_\_\_  
Feeling "down"/"blue" \_\_\_\_\_  
Marital problems \_\_\_\_\_  
Anxiety \_\_\_\_\_

### Endocrine

Hair loss \_\_\_\_\_  
Feeling hot/cold \_\_\_\_\_  
Excessive thirst \_\_\_\_\_  
Frequent urination \_\_\_\_\_

### Hematologic

Unusual bleeding \_\_\_\_\_  
Unusual bruising \_\_\_\_\_  
Anemia \_\_\_\_\_  
Enlarged lymph nodes \_\_\_\_\_

### Women

Date of last menstrual cycle \_\_\_\_\_  
Irregular menstrual cycle \_\_\_\_\_  
Normal cycle length \_\_\_\_\_ days  
Number of pregnancies: \_\_\_\_\_  
    Live births: \_\_\_\_\_  
    Miscarriages: \_\_\_\_\_  
    Abortions: \_\_\_\_\_  
Last Pap smear \_\_\_\_\_  
Irregular Pap smears \_\_\_\_\_  
Last mammogram: \_\_\_\_\_  
Irregular mammograms \_\_\_\_\_  
Trouble with sex \_\_\_\_\_  
Painful menstrual periods \_\_\_\_\_

### Men

Trouble urinating \_\_\_\_\_  
Trouble starting/stopping  
urinary stream \_\_\_\_\_  
Change in urine stream \_\_\_\_\_  
Trouble with erections \_\_\_\_\_  
Trouble with sex \_\_\_\_\_

### Legal

Do you have a living will and/or  
power of attorney? \_\_\_\_\_

### Abuse

Have you been a victim of  
abuse?  
    Physical \_\_\_\_\_  
    Sexual \_\_\_\_\_  
    Emotional \_\_\_\_\_

### Safety

Do you feel safe at home? \_\_\_\_\_  
Do you need community  
resources? \_\_\_\_\_

# COMPREHENSIVE PHYSICAL EXAMINATION

(For Office Use Only)

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ ♀ ♂ Date of Birth: \_\_\_\_\_

Vitals: Temp \_\_\_\_\_ Pulse \_\_\_\_\_ B/P \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**NORMAL FINDINGS**

**ABNORMAL FINDINGS – NOTES**

**1. GENERAL APPEARANCE**

- General Health     Body Build
- Apparent Age     Posture

**2. SKIN**

- Texture                       No Skin Lesion
- Color                          Nails

**3. HEAD & NECK**

- Scalp     Nose     Neck
- Ears     Sinuses     Jugular
- Hearing     Mouth     Carotids
- Eyes     Tongue     Thyroid
- Teeth     Visual Acuity
- No Adenopathy     Fundi
- Throat

	500	1000	2000	4000
RT ear				
LT ear				

RT eye	20 /
LT eye	20 /

**4. THORAX, HEART & LUNGS**

- CHEST:     No Deformity     No Tenderness
- No Masses         No Lymphadenopathy
- HEART:     Rate                 Regular Rhythm
- No Murmurs       No Ectopic Beats
- No Gallop         Apex Beat-Normal Loc.
- LUNGS:     Excursions Normal
- No Adventitious Sounds
- No Wheezing/Rales
- BREASTS:  Normal     No Masses     Size, Symmetry, Discharge

**5. ABDOMEN**

- No Tenderness     No Masses     No Surgical Scars
- No Hernia          No Liver Enlargement
- Normal Peristaltic Sounds     Inguinal Nodes

**6. GENITALIA**

- |  |   |
|--|---|
| <p><b>MALE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Penis    <input type="checkbox"/> No Lesions</li> <li><input type="checkbox"/> Testicles    <input type="checkbox"/> No Discharge</li> <li><input type="checkbox"/> Prostate    <input type="checkbox"/> No Hernia</li> </ul> | <p><b>FEMALE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Vulva    <input type="checkbox"/> Cystocele</li> <li><input type="checkbox"/> Cervix    <input type="checkbox"/> Rectocele</li> <li><input type="checkbox"/> Uterus    <input type="checkbox"/> Enterocele</li> <li><input type="checkbox"/> Adnexa</li> </ul> |
|--|---|
- Gland: Normal Size, Non-Tender

**7. ANAL, RECTAL**

- No Masses     Minimal or Absent Hemorrhoids
- Sphincter Tone     Stool – Negative Hemotest

**8. MUSCULOSKELETAL SYSTEM**

- EXTREMITIES:     No Clubbing     No Swelling
- No Deformities     ROM
- BACK:     No Abnormal Curvature     Straight Leg Raise
- No Pain or Tenderness     No Limitation of Motion

**9. PERIPHERAL VASCULAR SYSTEM**

- Carotids                       Abdominal Aorta     Femorals
- Dorsal Pedis                 Posterior Tibials     No Bruits

**10. NEUROLOGICAL**

- Cranial Nerves     Pupils                       Normal Gait
- Coordination     No Weakness / Paralysis     Romberg Test
- Deep Tendon Reflexes     Sensory Exam               No Tremors

**11. MENTAL STATUS**

- Behavior                       Mood                         Speech
- Language                       Cognitive                       Orientation
- Attention                       Function                       Memory

