Internal Medicine Associates of Charlotte, P.A.

Physical Exam Form

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Influenza

Current and previous medical conditions

Year	Condition	Year	Condition	Year	Condition

Surgeries/Hospitalizations

Year	Reason	Hospital

Specialty Doctors you see:

Physician	Address	Phone	Specialty

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength/ Frequency Taken	Why You Are Taking	Start Date

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
Diet	Current diet:		
	Significant weight loss/gain in the last year? ☐ Yes ☐ No Loss of Appetite?	☐ Yes	☐ No
Caffeine	☐ None ☐ Coffee # per day ________ ☐ Tea # per day________ ☐ Cola # per day ________		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week? ________		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes - packs/day ________ ☐ Chew - #/day _____ ☐ Pipe - #/day________ ☐ Cigars - #/day ________		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	Type of contraceptive or barrier method used:		
Personal Safety	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you wear seat belts?	☐ Yes	☐ No
	Do you have an Advanced Directive or Living Will?	☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever attempted suicide or thought about hurting yourself?	☐ Yes	☐ No

WOMEN ONLY

Date of last menstruation: Period every _____ days Age of menopause:		
Any urinary tract, bladder, kidney infections or problems with control of urination within the last year?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night? If yes, # of times _____	☐ Yes	☐ No
Do you feel pain, burning with urination or have blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have any symptoms and briefly explain.

☐ Abnormal moles on your skin	☐ Chest pain	☐ Headaches
☐ Blurry vision	☐ Back pain	☐ Anxiety
☐ Dizziness	☐ Incontinent of urine	☐ Depression
☐ Nosebleeds	☐ Blood in your stool	☐ Change in energy level
☐ Hoarseness	☐ Gout	☐ Thoughts of suicide or hurting yourself
☐ Shortness of breath	☐ Blood clots	☐ Other:

MEDICAL SCREENING HISTORY

Date of Last:

Complete Physical Exam		Cholesterol Test	
Breast Exam		Stool Blood Test	
Mammogram		Colonoscopy	
Pap Smear		Prostate Exam	
Rectal Exam		Testicular Exam	
EKG		Eye Exam	
Stress Test		Dental Exam	

Any other problems you are having that you would like to discuss today:

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______________________________ Patient Signature

______________________________ Date

______________________________ Reviewed by

______________________________ Date