Internal Medicine and Pediatrics Associates, PA

Established Patient Questionnaire

Name: ___________________________________ DOB: _________ Today's Date: _________

Drug Allergies: ____

Please complete the following confidential questionnaire for your Annual Physical Exam. This is a screening tool to identify possible health problems early, provide counseling, and update health history. If you have any specific concerns that are addressed and not considered "preventive", then this MAY result in a separate office visit charge in addition to the preventive exam charge, or may require a separate scheduled visit in order to adequately address all concerns.

1. Do you have any health concerns for today? ____
   ____

2. Are you currently under the care of any other **physicians**? If so, please list:
   ____

3. List all medications that you are currently taking daily. (Including over the counter medications and herbal supplements). Include dosage and frequency. (May add additional page if needed)
   a. ______________________________ d. ______________________________
   b. ______________________________ e. ______________________________
   c. ______________________________ f. ______________________________

4. List all **NEW surgeries / procedures you have had (including outpatient) since your last physical exam**, and their approximate dates:
   ____

Where appropriate, please circle "yes" or "no" for each question.

5. Do you wear glasses or contact lenses? Yes No *Date of Last Eye Exam:* _______________
6. Do you currently smoke? Yes No
   If yes, packs per day: _____ *Years:* _____ *Quit?* _____ *When?* ________
7. Do you use oral tobacco, "vape" or use any illegal substances: Yes No
8. Do you drink alcohol? Yes No
   If yes, drinks per day: _____ *Per Week:* _____ *Quit?* _____ *When?* ________
9. Do you get regular aerobic exercise? *(30 min. per day, 3 – 4 days per week)* Yes No
10. Please list if a blood relative (grandparent, parent, sibling, or child) has developed any **additional** diseases this year:
    ____

11. ***For Women Only***
    a. Have you ever been pregnant? Yes No
       If yes, how many times? _______ *Number of children?* _______ *Date of last menstrual period?* ____________________
    b. Are you sexually active? Yes No
       If yes, how many sexual partners do you have? _______ *Is (Are) your sexual partner(s) male or female?* ______________________
    c. Do you use birth control? Yes No
       If yes, what kind? ____ *Date of last Pap smear?* ________________________
    d. Do you do breast self-examinations? Yes No
       *Date of last Mammogram?*________________________

10. ***For Men Only***
    a. Are you sexually active? Yes No
       If yes, how many sexual partners do you have? _______ *Is (Are) your sexual partner(s) male/female?* _______________________
    b. Do you do testicular self-examinations? Yes No

Continue to back >>>>>

Name: ____ Date: __________________________________

Internal Medicine and Pediatrics Associates, P.A.

Please answer the following general questions about your current state of health.

General / Constitutional

1) Have you had a change in weight? ………………………………………………………… Yes No
2) Have you had a change in general health? ……………………………………………… Yes No
3) Have you had fevers / chills / night sweats? ………………………………………….. Yes No

Skin / Breast

4) Do you have any concerns about your hair, skin or nails? ……………………………. Yes No
5) Have you noticed any problems with your breasts? ……………………………………... Yes No

Eyes / Ears / Nose / Mouth / Throat

6) Do you have frequent or otherwise troubling headaches? …………………………………. Yes No
7) Have you had a change in vision? …………………………………………..………………. Yes No
8) Do you have difficulty breathing through your nose? ……………………….………………. Yes No
9) Are there any other concerns about eyes / ears / mouth / throat? ……………………………. Yes No

Cardiovascular

10) Do you ever have problems with chest pain? ……………………………………………….. Yes No
11) Do you have problems with irregular / fast heart beats? ……………………………………. Yes No
12) Do you have problems with swelling in the legs? ……………………………………………. Yes No
13) Does walking predictably result in leg pain? …………………..……………………………… Yes No

Respiratory

14) Do you have a problem with cough? ………………………………………………………….... Yes No
15) Have you ever had asthma or been treated with inhalers? …………………………………… Yes No
16) Do you ever have difficulty breathing? ………………………………………………………… Yes No

Gastrointestinal

17) Do you have heartburn, abdominal pain, or difficulty swallowing? ………………….…… Yes No
18) Do you have frequent diarrhea or constipation? …………………………………………….. Yes No
19) Have you had blood in stools or black / tarry stools? ……………………………………….. Yes No
20) Do you have any other concerns about your digestion? ……………………..……………...Yes No

Genitourinary

21) Do you have problems with frequent urinary infection? …………………………………….. Yes No
22) Do you have difficulty with urinary incontinence or blood in the urine? ……………………. Yes No
23) Do you have problems with initiating a urinary stream or frequently urinating at night? …… Yes No
24) Are you having any physical problems sexually?…………………………………………………..Yes No

For Women Only

25) Do you have any vaginal discharge or itching? ……………………………………………… Yes No
26) Have you had any vaginal bleeding since you have been menopausal greater than six months? Yes No
27) Are your period's irregular? ……………………………………………………………………………Yes No

Musculoskeletal

28) Do you have pain in any joints or muscles? ………………………………………………….. Yes No
29) Do you have any weakness? ………………………………………………………………………. Yes No

Neurologic / Psychiatric

30) Have you noted any change in your sensation, strength or coordination? ……………….… Yes No
31) Are you concerned about memory problems? …………………………………………………Yes No
32) Do you have good quality sleep?...Yes No
33) Is your mood predominantly anxious or depressed? …………………………………………. Yes No
34) Have you had any falls in the past year? ……………………………………………………… Yes No
35) Are you experiencing any stressful issues in your life? ……………………………………… Yes No
(Job, finances, marriage, family, etc.)