New Providence Internal Medicine Associates

Instructions for Physical Exam:

Please review the following so you can get the most out of your upcoming physical exam:

- If this is your first complete physical at our practice, please complete every section.
- If you have had a complete physical at our practice since 2010, only complete sections where there is a change.
- We request that at every physical, each person fill in all of the following:
    - Medications (including supplements and vitamins)
    - Other doctors who are treating you
    - Review of symptoms

Please do not use any lotion on your chest, as we may want to do an EKG.

Do write down any specific questions that you may have.

It is VERY IMPORTANT that you bring the completed form with you on the day of the physical. Please arrive 10 minutes prior to your scheduled time, so our nurses can review your forms before seeing the doctor.

Thank you.

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COMPREHENSIVE PREVENTIVE CARE VISIT

(PREVENTIVE VISIT DOES NOT INCLUDE TREATMENT OF NEW OR ONGOING PROBLEMS)

Your name: _____ Date of physical: _____

Doctor you are seeing: _____ Date of birth: _____ Your age: _____

Please list all medications, supplements, vitamins, etc., and list all other doctors who are treating you. Fee l free to use additional sheets if needed.

Name	dosage	When do you take it	comments

Please list any other doctors who are currently treating you: _____

ONLY COMPLETE ANY SECTION BELOW WHICH HAS CHANGED SINCE YOUR LAST PHYSICAL:

1. Ongoing health problems: _____
2. Past health problems: _____
3. Past surgeries: _____
4. Hospitalizations, not for surgical problems: _____
5. Allergies to medications: _____
6. Family history: (list health problems, especially cardiovascular and cancers):

	Age (or year of birth) (if living)	Age when deceased	Health problems and conditions
Father			
mother			
sibling			
sibling			

7. Do you drink alcohol? If yes, how many drinks per week (one drink is 2 ounces of hard liquor, 5 ounces of wine, or 12 ounces of beer): _____
8. Do you currently smoke cigarettes: _____ if yes, how many packs per day? _____ At what age did you start smoking? _____ If you smoked in the past, at what age did you start? _____ At what age did you stop? _____ How many packs a day had you smoked? _____
9. Are you on a special diet (e.g. vegetarian, gluten free, etc.)? _____
10. Do you have a living will or advanced directive? _____
11. What type of regular exercise do you do? _____
12. What type of work do you do?_____ How many hours a week do you work? _____
13. What is your marital status: _____ How many children do you have? _____
14. Do you wear seatbelts when you drive or are a passenger?_____
15. Have you ever used intravenous drugs in the past? _____

16. How would you describe your health overall?_____
17. Are you: heterosexual, homosexual, bisexual? (circle one)
18. How many hours of TV do watch a week?: _____

Please circle any symptoms which currently or significantly apply to you:

Headache	Men only:
Spinning of the room	• difficulty with erections
Weakness on one side of your body	• Loss of power of urinary stream
Numbness of hands or feet	Women only:
Black out or faint	• vaginal bleeding in between periods or after menopause
Shortness of breath	• Age at menopause: _____
Wheezing	
Cough	Ongoing or severe back pain
Cough up blood	Difficulty with coordination
Pain or tightness in chest with exertion	Falls
Palpitations	Tremor
Pain in the stomach	Fatigue
Severe heartburn	Sleep:
Food sticks when you swallow	• How many hours do you sleep at night? ____
Loss of appetite	• Ever stop breathing during sleep?
Nausea	• Difficulty falling asleep or staying asleep
Vomiting	
Unintentional weight loss	Swelling of the ankles
Blood in the stool	lightheadedness
Constipation	Memory loss
Diarrhea	Depression
Black stool	Anxiety
Pain in joints	
Rash or lumps on your skin	Date of Last General Screening:
History of skin cancer	• Mammogram
Do you use sunblock?_____	• Pap test
Difficulty with vision	• Bone Density (DEXA)
Last eye doctor visit: _____	• Colonoscopy
Painful urination	• Stool test for blood (hemoccult)
Blood in the urine	
Loss of urine (incontinence)	List the date of Last Immunizations:
History of kidney stones	• Influenza (flu shot)
How many times do you wake at night to urinate? ___	• pneumonia
	• Tetanus/Adacel
	• Shingles/Zostavax

Any other questions or issues to discuss with the doctor?