

**ANNUAL/PREVENTIVE EXAMINATION
THE AUSTIN DIAGNOSTIC CLINIC**

PATIENT NAME: _____
DATE: _____
MRN: _____

REASON FOR VISIT: _____ **AGE:** _____

Any major medical illnesses or surgeries in the past year? _____

Any other physician visits in the past year? _____

FAMILY HISTORY: Have there been any new illnesses or deaths in your family in the past year? _____

SOCIAL HISTORY: OCCUPATION: _____ HOURS/WEEK? _____

MARITAL STATUS: _____ NUMBER OF CHILDREN: _____

DIET: (CIRCLE) Regular Low Cholesterol Low Fat Low Sodium Diabetic Other: _____

EXERCISE: Type _____ How often? _____ For How Long? _____

ALCOHOL CONSUMPTION: Amount _____ How Often? _____

TOBACCO USAGE: YES/NO Amount _____ Frequency _____ Quit Date _____

Cessation counseling desired: YES/NO _____ DO YOU WEAR SEATBELTS: YES/NO _____

REVIEW OF SYSTEMS: In general, how do you feel? _____ How is your energy level? _____

Has your weight fluctuated more than 10 pounds in the past year? _____

HEENT: Any significant changes in vision? _____ Hearing? _____

Any pollen allergies or bad nasal drainage? _____ Other: _____

RESPIRATORY: Any chronic cough, chest congestion or shortness of breath? _____

Any coughing up of blood? _____ Other: _____

CARDIOVASCULAR: Any chest pain, pressure or tightness? _____

If so, what brings it on? _____ Any heart palpitations or irregular heart beat? _____

Any edema or swelling? _____ Any leg cramps with walking? _____

GI: Any chronic or severe indigestion? _____ Any pain or difficulty swallowing? _____

Any change in bowel habits, diarrhea or constipation? _____ Any blood in your stool? _____

GU: Any burning with urination? _____ Any difficulty urinating? _____

Any blood in your urine? _____ Increased frequency of urination? _____

Frequency of nighttime urination: _____ Leakage of urine: _____

MEN: Do you do monthly self-testicular exams? _____ Any lumps or pain noted? _____

Any impotence or sexual dysfunction? _____ Medical treatment desired? _____

WOMEN: Date of last mammogram, if applicable: _____ Do you perform monthly self-breast exams? _____

Any breast pain, discharges or lumps? _____

Are menstrual periods regular? _____ Date of last period: _____

Any vaginal discharge, discomfort or unexpected bleeding? _____

Any pain with intercourse? _____ Method of contraception: _____ Date of menopause or

hysterectomy: _____ Other: _____

MUSCULOSKELETAL: Any chronic or bothersome arthritis or joint pain? _____ If so, which joints?

_____ Any chronic or severe back pain? _____

Any unusual muscle aches or cramping? _____

SKIN: Any skin lesions that growing, changing, or need attention? _____ What area? _____

SLEEP: Are you sleeping well? _____ Numbers of hours per night: _____

PSYCHOLOGIC: Is stress level high, low or average? _____ Any feeling of anxiety, depression, or

nervousness? _____

NEUROLOGIC: Any chronic or unusual headaches? _____ Any numbness or tingling?

_____ Any lightheadedness, dizziness of fainting spells? _____

OTHER: _____