

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

PATIENT NAME: _____

DATE: _____

MRN: _____

(Patient label)

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? _____ 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

Caffeine drinks/day _____ Sexually active _____ (Y/N)

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 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 palpitation or irregular heartbeat? _____

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, discharge or lumps? _____

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

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 are growing, changing or need attention? _____ What area? _____

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

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

Nervousness? _____

NEUROLOGIC: Any chronic or unusual headaches? _____ Any numbness

or tingling? _____ Any lightheadedness, dizziness or fainting spells? _____

OTHER: _____

PHYSICAL EXAMINATION

CONSTITUTIONAL:

WEIGHT: _____
HEIGHT: _____ HR: _____
BP: RA _____ LA _____
GENERAL: _____

EYES:

CONJ/ LIDS: WNL POS:
PUPILS/ IRIS: WNL POS:
RETINAL EXAM WNL POS:

ENMT:

EXTERNAL: WNL POS:
TMS: WNL POS:
HEARING: WNL POS:
NASAL MUCOSA: WNL POS:
LIPS/ TEETH: WNL POS:
OROPHARYNX: WNL POS:

NECK:

SYM/ TRACHEA: WNL POS:
MASSES: NONE POS:
THYROID: WNL POS:

RESPIRATORY:

EFFORT: WNL POS:
PERCUSSION: WNL POS:
PALPITATION: WNL POS:
AUSCULTATION: WNL POS:

CARDIOVASCULAR:

PALPATION: WNL POS:
AUSCULTATION: WNL POS:
CAROTIDS: WNL POS:
EXTREMITIES: WNL POS:
OTHER CARDIO: _____

BREAST:

SYM/ NIPPLE: WNL POS:
MASSES: NONE POS:
SKIN: WNL POS:

GI:

MASS/TENDER WNL POS:
LIVER/ SPLEEN: WNL POS:
HERNIA: NONE POS:
RECTUM/ANUS: WNL POS:
OCCULT SAMPLE: NEG POS:
 NO STOOL

GU: (MALE)

PENIS: WNL POS:
SCROTUM/TESTICLES: WNL POS:
PROSTATE: WNL POS:

GU: (FEMALE)

VULVA: WNL POS:
VAGINA: WNL POS:
CERVIX: WNL POS:
PAP SMEAR: YES NO
NOT REQUIRED
UTERUS/ADNEXA: WNL POS:
ABSENT

LYMPHATIC:

AREA: CERVICAL WNL POS:
AREA: AXILLARY WNL POS:
AREA: INGUINAL WNL POS:

OTHER: _____

MUSCULOSKELETAL:

GAIT/ STATION: WNL POS:
DIGITS/ NAILS: WNL POS:
JOINTS/ROM: WNL POS:
MUSCLE STRENGTH/ TONE: WNL POS:
BACK: WNL POS:

SKIN:

RASH/ LESIONS: WNL POS:
INDURATION/ NODULES: WNL POS:

NEURO:

CRANIAL: WNL POS:
SENSORY: WNL POS:
DTRS: WNL POS:

PSYCH:

JUDGEMENT: WNL POS:
MOOD/ AFFECT: WNL POS:

ANTICIPATORY GUIDANCE AND PATIENT TEACHING: ADC PREVENTIVE GUIDELINES BROCHURE PROVIDED

DIET: AHA ADA LOW SALT
LOW FAT LOW CAL REGULAR
HIGH FIBER OTHER: _____

EXERCISE: AEROBIC BACK
OTHER: _____

SMOKING CESSATION COUNSELING: N/A DISCUSSED REFUSED

ETOH/ DRUG ABUSE: N/A
DISCUSSED ABUSE/TREATMENT

FALL PREVENTION IN ELDERLY DISCUSSED/INFORMATION GIVEN

SELF EXAM: BREAST TESTICULAR
TAUGHT ALREADY PERFORMING

CANCER SCREEN RECOMMENDED: MAMMO, DUE DATE: _____ PSA, DUE DATE: _____ SKIN CANCER PREVENTION DISCUSSED/INFORMATION GIVEN

COLON SCREENING: FOB x 3
FFS RECOMMENDED
COLONOSCOPY RECOMMENDED

STD/ SAFE SEX: TESTING REQUIRED
COUNSELING/INFORMATION GIVEN

CONTRACEPTION: N/A
DISCUSSED OPTIONS
DISCUSSED RISKS

ADVANCED DIRECTIVE/LIVING WILL:
ON RECORD
DISCUSSED/INFORMATION GIVEN

SCREENING TESTS (NO DIAGNOSIS):
ASSESSMENT/PLAN DICTATED

SIGNATURE: _____