

Virginia Beach Premier Medical

Annual Health Assessment

Name: _____ Date: _____

Any new problems or symptoms? _____

Do you have a list of your medications or will you bring them with you? _____

List all allergies _____

How much do you exercise? _____

How would you describe your nutritional status? _____

Do you smoke? _____ Drink alcohol? _____

Any other substance usage? _____

Have you had any surgery or illness since your last visit? _____

Any changes in your family history? _____

Any tests done since your last visit? _____

Review of Systems

Check any of the following problems that you have had now or in the past:

General

fever, sweats, unusual fatigue

Head and Neck

change in vision, change in hearing, _____ Last eye exam, ringing in ears, nosebleeding,
 hoarseness, chronic sinus congestion, frequent runny nose, frequent or unusual headaches

Chest

Shortness of breath, recurring cough, excessive snoring, wheezing/asthma,
 coughing up blood, chest discomfort, heart pounding or racing, swelling in feet or legs

Blood/Lymphatics

enlarged lymph glands, anemia, prior blood transfusion, easy bruising

Gastrointestinal

Indigestion, heartburn, acid reflux/ history of ulcer, difficulty swallowing, nausea/vomiting,
 Recurring diarrhea, Constipation, blood in stool, black stools, hepatitis,
_____ last colonoscopy

Endocrine

high blood sugar, thyroid problem, excessive thirst, always too hot or too cold,
 weight change

Genitourinary

frequent urination, Pain on urination, blood in urine, inability to control bladder,

Men: slow urination, _____# urinations at night, erectile dysfunction

Women: abnormal periods, discharge, hot flashes, breast lump/discharge,
 last mammogram, last PAP, _____# of pregnancies, # of deliveries, _____last period.

Musculoskeletal/ Neuro

arthritic pain, memory loss, poor balance, numbness or weakness, tremor

Other

chronic allergic sinus problems, frequent infections, skin rashes or sores,
 mood changes, excessive irritability, insomnia, anxiety, depression

General Health Assessment

Do you feel healthy? _____

Do you have difficulty coping with stress? _____

Are you having any significant pain? If so, where and how bad is it? _____

Fitness:

Do you do any aerobic exercise (walking, running, bicycling, swimming, tennis, etc.)? _____

Any weight-bearing exercises? _____

Daily stretching exercises? _____

Functional Ability/Safety

Have you fallen any within the last 3 months? _____

Can you get up from the floor or from a chair without help? _____

Are there any electrical cords or throw rugs in the travel areas in your home? _____

Do you have adequate lighting in your home? _____

Do you always wear seat belts in the car? _____

Do you need help with shopping, preparing meals, managing medications, housework, paying bills and balancing your checkbook? _____

Do you need help with __dressing, __bathing, __toileting, or other activities of daily living? _____

Do you ever drink alcohol and drive? _____

Do you wear a helmet if you ride a motorcycle or bicycle? _____

Are you a victim of emotional, verbal or physical abuse? _____

Do you wear glasses or contact lenses? _____ Are you supposed to wear them? _____

Do you have trouble hearing normal conversation? _____

Do you brush your teeth and floss every day? _____

Do you visit the dentist regularly? _____

Any broken bones over the past 5 years? _____

If female, did you go through menopause or have you had both ovaries removed before age 45? _____

Ever been exposed to anyone with tuberculosis? _____

Are you sexually active? _____

Any high risk sex? _____

Ever had tattoos or been exposed to unclean needles? _____

Do you frequently feel nervous or anxious? _____

Can't stop worrying? _____

Losing interest in everything? _____

Feeling hopeless or depressed? _____

Do you have a living will or an advance directive? _____

Prevention

Last colonoscopy _____ By whom _____

Last Bone density _____

Last general blood work and urine testing _____

Last Pneumonia vaccine _____

Last flu vaccine _____

Last tetanus booster _____

Shingles vaccine _____

Hepatitis vaccine A or B _____

Females:

Last Gyn exam _____

Last Mammogram _____

Males:

Last prostate exam _____