VANTAGE physicians

Adult Female Physical Form

Name: _____ DOB: _____

Are there any new problems, concerns, or recent surgeries since last physical? _____
_____
_____
Please list all medications: _____
_____
_____

Please note: If you have filled out this form before you may answer only those questions whose answer has changed during the interim.

Yes	No	
		- TOBACCO -
___	___	Do you smoke or chew? Packs per day? _____ How long? _____
___	___	Ever quit? _____ Want to quit?_____
		- EXERCISE -
___	___	Do you exercise regularly?
		If so: Some | Moderate | Athletic | Elite Athlete
		- SLEEP -
___	___	Do you have problems going to sleep?
___	___	Do you have problems staying asleep?
___	___	Do you snore?
___	___	Have you ever been told you stop breathing while asleep?
___	___	Do you have daytime drowsiness?
		- DIET -
___	___	Do you eat vegetables daily?
___	___	Do you eat red meat regularly?
___	___	Do you eat fried foods regularly?
___	___	Do you add salt to your foods regularly?
___	___	Do you drink or eat milk products regularly?
___	___	Do you ever eat in secret or feel bad or guilty about eating?
		- CAFFEINE -
___	___	Do you drink caffeinated drinks?
		If so what and how many cups or cans per day? _____

Yes No **- ALCOHOL -**

___ ___ Do you drink? Frequently | Occasionally | Rarely | Drinks per day? _____
___ ___ Have you ever felt the need to cut down?
___ ___ Have you ever felt annoyed by criticism of drinking?
___ ___ Have you every felt guilty about drinking?
___ ___ Have you ever taken an "eye opener"?

- NON-PRESCRIPTION DRUGS -

___ ___ Do you use over-the-counter medications or vitamins?
If so please include these in your medication list above.
___ ___ Have you used anything other than alcohol to get high?
If so what and when last used? _____

- BOWEL or BLADDER PROBLEMS -

___ ___ Are you having any bowel problems?
Constipation \ Diarrhea \ Hemorrhoids \ Bleeding \ Other
___ ___ Have you ever had a colon exam (i.e., flexible sigmoidoscopy or colonoscopy)?
If so when and where? _____
___ ___ Are you having any difficulties with urination?
Frequency | Loss of Control | Dribbling |
___ ___ Do you get up in the night to urinate? If so how many times at night? _____
___ ___ Have you had any injuries, infections or surgeries involving your genitalia?
If so what and when? _____

- FEMALE HISTORY -

___ ___ Are you having any female problems or concerns?
How many times pregnant: _____ Live Births: _____
Miscarriages: _____ Terminations: _____
How old at first period? _____ Last menstrual period? _____
Days between periods? _____ Days of bleeding? _____
Flow: Heavy | Medium | Light
___ ___ Have you ever had an abnormal Pap Smear?
When was your last Pap? _____
___ ___ Have you ever had a pelvic or vaginal infection or surgery
___ ___ Do you do breast self-exams? Do you know how? _____
___ ___ Have you had a mammogram?
Date of last mammogram? _____ Results? _____
___ ___ Have you had a bone density test or DXA scan?
Date of last bone density? _____ Results? _____

- SEXUAL HISTORY -

___ ___ Are you having any sexual difficulties that you would like to discuss?
___ ___ Do you have any questions or concerns about contraception?
___ ___ Any pain during sex?

Yes No **- IMMUNIZATIONS & INFECTIONS -**

___ ___ Have you received an MMR update? If so when and where? _____
___ ___ Have you received the Hepatitis B Vaccine Series? If so when and where? _____
___ ___ Have you received a Tetanus shot in the last 10 years? If so when and where?___
___ ___ Have you had Chickenpox or the Varicella Vaccine? If unsure, would you like to be tested? _____
___ ___ Have you ever been tested for Hepatitis C? Would you like to be tested? _____
___ ___ Have you ever been tested for HIV? Would you like to be tested? _____
___ ___ Have you received a Pneumovax? Would like to receive one?_____
___ ___ Do you get annual Flu Vaccines?

- EXPOSURE RISK -

___ ___ Have you ever been exposed to any of the following materials or substances.
- Asbestos - Mineral Dusts - Benzene/Toluene - Chlorinated Solvents -
- Petroleum - Fuels - Fumes - Lead - Arsenic - Cadmium - Mercury -
- Radiation - PCB's - Insecticides - Other Exposures

Please circle and please note when, where and how significantly: _____
_____

___ ___ If exposed to any of the above, have you been evaluated for this before?
If so when and where? _____

- MOOD and MEMORY HISTORY -

Over the last two weeks, have you:

___ ___ Felt sad, depressed or hopeless?
___ ___ Felt unusually anxious or over-whelmed by your emotions?
___ ___ Noticed that others might think you are depressed or sad?
___ ___ Had changes in your sleep or appetite?
___ ___ Lost interest in previously enjoyable activities?
___ ___ Felt withdrawn or distanced from your friends or family?
___ ___ Had difficulty remembering events, names or conversations?
___ ___ Had difficulty with concentration or staying on task?

- REVIEW OF SYSTEMS -

Have you ever had any of the following, and if so please provide more information in the space below:

Yes	No		Yes	No	
___	___	Frequent or severe headaches?	___	___	Liver problems?
___	___	Head injury or concussion?	___	___	Blood in stool?
___	___	Frequent dizzy spells or lightheadedness?	___	___	Blood in urine?
___	___	Fainting spells or blackouts?	___	___	Hernia?
___	___	Convulsions or seizures?	___	___	Kidney problems?
___	___	Severe anxiety or depression?	___	___	Painful or swollen joints?
___	___	Allergies or hay fever?	___	___	Hand or wrist problems?
___	___	Dental problems?	___	___	Arm or shoulder problems?
___	___	Throat problems or hoarseness?	___	___	Neck problems?
___	___	Chest or lungs problems?	___	___	Lower back problems?
___	___	Asthma?	___	___	Knee, hip or ankle problems?
___	___	Lung infections?	___	___	Anemia or low blood count?
___	___	TB or a positive TB Test?	___	___	Iron or other vitamin deficiency?
___	___	Persistent cough?	___	___	Cancer or tumor?
___	___	Chest pain with activity?	___	___	Significant weight change?
___	___	Heart problems or heart attack?	___	___	Severe infections?
___	___	High blood pressure?	___	___	Hospitalizations?
___	___	Persistent stomach pain?	___	___	Fever or night sweats?
___	___	Thyroid problems?	___	___	Skin lesions or rashes?
___	___	Diabetes?	___	___	Significant unexplained fatigue?
___	___	Gallbladder problems?	___	___	Significant or unexplained muscle pain?

Further information: _____

_____

_____

_____

_____

_____

_____

The above is true and correct to the best of my knowledge.

_____ _____

Patient signature Date Reviewed by Date

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