



# 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 ExposuresPlease 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?

