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

Patient name: ______________________________________ DOB: _____________ Date: ______________________

REASON FOR VISIT: ____ **PROVIDER NAME**: _____________

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

Any other physician visits in the past year? ____

FAMILY HISTORY: Has 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

REVIEW OF SYSTEMS: In general, how do you feel? _____________ How is your energy level? ________________
Has your weight fluctuated more than 10 pounds in the last 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 heartbeat?__________________ Any edema or swelling? ____________________
Any leg cramps while 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 pain with intercourse? ___________ Method of contraception: ______________
Anyvaginal discharge, discomfort or unexpected bleeding? ____
Date of menopause or hysterectomy: ____________ Other:____

MUSCULOSKELETAL: Any unusual muscle aches or cramping? ____
Any chronic or bothersome arthritis or joint pain? ___________ If so, which joints? _____________________________

SKIN: Any skin lesions that are growing, changing or need attention? ___________ what area? ________

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

PSYCHOLOGICAL: Is stress level high, low, or average?________________ Any feelings of anxiety, depression or

nervousness?____

NEUROLOGICAL: Any chronic or unusual headaches?_______________ Any numbness or tingling?_______________
Any lightheadedness, dizziness or fainting spells? ____

OTHER INFORMATION FOR PROVIDER:____