ANNUAL PHYSICAL QUESTIONNAIRE

Patient name: _____ Date of Birth: _____ Date of exam:_____

Physicians/Practitioners or Hospitals you have been to since your *last* visit

Name/Specialty	Name/Specialty
1. _____	3. _____
2. _____	4. _____

Do you use any tobacco products? □ Yes □ No If yes, what type?_____ How much? _____
Do you drink alcohol? □ Yes □ No If yes, how much?_____
Do you wear your seat belt? □ Yes □ No Do you wear sun protection? □ Yes □ No
Do you exercise? □ Yes □ No If yes, amount/type: _____

Diet: □ Balanced □ Vegetarian □ Diabetic □ Low salt □ Low fat □ Low carb □ Other: _____

Please provide the *last* date if you had the following:

Flu vaccine: __/___/___
COVID Vaccine: (1st) ___/___/___ (2nd) ___/___/___ (3rd) ___/___/___ Brand: _____
Any additional vaccines since last visit: _____

Colonoscopy or Sigmoidoscopy: ___/___/___ Where? _____
DEXA: ___/___/___ Where? _____ Eye Exam: ___/___/____ Where? _____
Aorta Ultrasound: ___/__/___ Where? _____ HIV Screen: ___/___/____ Where? _____
Hep C Screen: ___/___/___ Where? _____ Hearing Evaluation: ___/___/____ Where? _____
Last Pap Smear: ___/___/___ Where? _____

Last Mammogram: ___/___/____ Where? _____ Do you perform monthly self-breast exams? ___
Do you have breast lumps/nipple discharge? _____

<u>Sexual History</u>

Do you have known risks for HIV or other Sexually Transmitted Infection? _____
Are you sexually active?: __ Yes __ No If so, with: (circle all that apply) Men Women Both
Have you had multiple sexual partners in the last 6 months? __ Yes __ No
Have you been treated for a Sexually Transmitted Infection in the past year: __ Yes __ No
Do you use condoms? __ Yes __ No Do you use a Birth Control Method? _____

Do you have an Advance Directive or Power of Attorney? _____ Would you like information? _____

_____ _____
Patient Signature Date