Lake Country
Medical Concierge

(706) 817-9464 - 119 Harmony Crossing STE 3, Eatonton, GA 31024

COMPREHENSIVE PHYSICAL EXAMINATION QUESTIONNAIRE

Name_________________________________ **Date**____________________________________

Date of Birth: _________________________ Age: _____________

What Medical Concerns do you have?

____

____

Allergies:

Are you allergic to any drugs? (Please Circle) Yes No

If yes, please list ____

Are you allergic to shellfish? (Please Circle) Yes No

Are you allergic to iodine? (Please Circle) Yes No

Are you allergic to bee stings? (Please Circle) Yes No

Are you allergic to any foods? (Please circle) Yes No

If yes, please list ____

Medications:

Please list any medications you are currently taking. Please include the dosage (mg) and frequency (times per day)

____

____

____

Family History

Has any blood relative ever had? (Circle and indicate relationship on the line behind the condition)

Alzheimer's __________	Tuberculosis __________	Bleeding Disease __________
Heart Attack __________	Thyroid Disease __________	Asthma __________
Alcoholism __________	Stroke __________	Diabetes __________
Seizures __________	Allergies __________	Depression __________
Heart Disease __________	Cancer __________	Other:

Personal Health Concerns

Please circle those items that have been a recurrent or significant change.

Recent significant weight change	Fatigue or weakness	Blood in urine
Frequent urination	Fever, chills, night sweats	Change in vision
Burning or pain on urination	Change in force or strain when urinating	Incontinence or dribbling of urine
Blurred or double vision	Eye disease or injury	Wear glasses or contact lenses

Men:

Testicular Pain	Sexual difficulties	Other:

Women:

Painful periods	Irregular Period	Recurrent vaginal discharge
Date of last menstrual period: ________________	*Date of Last Pap Smear* ________________	*Date of last mammogram*:__________________

Ears/Nose/Mouth/Throat/Neck

Do you wear hearing aids?	Hearing loss or ringing in the ears?	Earaches or drainage?
Chronic sinus problems or runny nose	Nosebleeds	Mouth Sores
Bleeding gums	Sore throat, hoarseness or voice change	Difficulty swallowing
Lumps or swollen glands in neck		

Musculoskeletal

Joint pain (s)	Joint stiffness/swelling or warmth	Weakness of muscles or joints
Muscle Pain or recurrent cramps	Back pain	Neck pain or stiffness
Cold hands or feet		

Cardiovascular Integumentary

Chest pain or angina	Palpitations	Swelling in the feet, ankles or hands
Waking at night with shortness or breath	Shortness of breath	

(Skin/Breast)

Rashes or itching	Change in skin color or moles	Change in hair or nails
Varicose veins	Breast pain	Breast discharge or rash

Respiratory

Chronic or frequent cough	Shortness of breath	Asthma or recurrent wheezing

Neurological

Frequent or increasing headaches	Lightheadedness or dizziness	Convulsions/seizures
Numbness or tingling sensation	Tremors	

Gastrointestinal

Loss of appetite	Change in bowel movements	Nausea or vomiting
Rectal bleeding/blood in stool	Stomach/abdominal pains or heartburn	Frequent diarrhea
Excessive skin dryness		

Endocrine

Excessive thirst	Excessive urination	Heat or cold intolerance