COMPREHENSIVE ANNUAL REVIEW

NAME: _____ DOB: _____ DATE: _____

WHAT QUESTIONS/PROBLEMS DO YOU WANT TO DISCUSS?
ANY NEW MEDICAL PROBLEMS/ DIAGNOSIS SINCE LAST PHYSICAL?
ANY OTHER DOCTORS SEEN SINCE LAST PHYSICAL? (PLEASE LIST)
WHAT GOALS DO YOU HAVE FOR YOUR HEALTH THIS YEAR?
WHO LIVES WITH YOU IN YOUR HOME?

PLEASE CHECK ANY ITEMS THAT APPLY TO YOU:

I FEEL IN POOR HEALTH	□	NEW SKIN SPOTS OR RASHES	□
I FEEL IN GOOD HEALTH	□	SHORTNESS OF BREATH WITH ORDINARY ACTIVITIES	□
I HAVE NO APPETITE	□		
I'VE LOST WEIGHT WITHOUT TRYING	□	CHEST TIGHTNESS OR PAIN, ARM OR JAW PAIN WITH EXERTION	□
I'M NOT SLEEPING WELL	□		
I'M TIRED ALL THE TIME	□	I CAN'T WALK UP 2 FLIGHTS OF STAIRS WITHOUT RESTING	□
CHANGE IN EYESIGHT	□		
CHANGE IN HEARING	□	PERSISTANT COUGH	□
HEADACHES MORE THAN TWICE A WEEK	□	COUGHING UP BLOOD	□
		HOARSE VOICE	□
FREQUENT NOSEBLEEDS	□	LEG CRAMPS WITH WALKING THAT GO AWAY WITH REST	□
CONSTANT NASAL DRAINAGE	□		
FREQUENT SINUS INFECTIONS	□	FREQUENT JOINT PAIN	□
TROUBLE SWALLOWING	□	JOINTS STIFF MORE THAN 30 MINUTES IN THE MORNING	□
SNORE LOUDLY	□		
STOP BREATHING WHILE SLEEPING	□	I DRINK MORE THAN 2 ALCOHOLIC DRINKS A NIGHT	□
FREQUENT STOMACH PAIN	□		
FREQUENT HEARTBURN	□	I FEEL GUILTY ABOUT DRINKING	□
FREQUENT CONSTIPATION	□	I LIKE TO HAVE AN "EYE OPENER"	□
FREQUENT DIARRHEA	□	I'VE HAD A DUI	□
BLACK TARRY STOOLS	□	PEOPLE HAVE GOTTEN ANGRY AT ME FOR MY DRINKING	□
BLOOD IN STOOL	□		
LOSE CONTROL OF BOWELS	□	I FEEL FREQUENTLY SAD	□
VOMITING BLOOD	□	MY EATING IS OUT OF CONTROL	□
BLOOD IN URINE	□	I HAVE LITTLE INTEREST IN DOING THINGS I USED TO LIKE	□
PAINFUL URINATION	□		
GET UP MORE THAN TWO TIMES A NIGHT TO URINATE	□	I FEEL ANXIOUS OR ON EDGE	□
		I WORRY ABOUT LOTS OF THINGS	□
LOSE CONTROL OF BLADDER	□	I OFTEN FEEL PANICKY	□
WEAKNESS OR NUMBNESS IN ARMS OR LEGS	□	I CAN'T STAND TO BE COLD	□
		I'M ALWAYS HOT WHEN OTHERS ARE COLD	□
TREMBLING OR SHAKINESS	□		
I FEEL UNSTEADY	□	SEXUAL DIFFICULTIES	□
HAVE HAD RECENT FALLS	□		

DO YOU:	**YES**	**NO**
HAVE A DURABLE POWER OF ATTORNEY? -WHO? _____	□	□
HAVE A LIVING WILL OR A POLST FORM?	□	□
WEAR A HELMET WHEN RIDING A BIKE?	□	□
WEAR YOUR SEATBELT IN THE CAR?	□	□
FEEL SAFE IN YOUR OWN HOME?	□	□
WEAR SUNSCREEN WHEN IN THE SUN?	□	□
SMOKE CIGARETTES or USE OTHER TOBACCO PRODUCTS?	□	□
EXERCISE 3-5 TIMES A WEEK?	□	□
FOLLOW A SPECIFIC DIET?	□	□
ARE YOU SEXUALLY ACTIVE?	□	□
WANT AN HIV/AIDS TEST?	□	□