

Annual Exam Questionnaire-Female

Name: _____

DOB: _____

Constitutional

	Y	N
Unexpected weight change?	<input type="checkbox"/>	<input type="checkbox"/>
Poor energy or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
Fever or night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
Changes in appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep concerns?	<input type="checkbox"/>	<input type="checkbox"/>

ENT

	Y	N
Visual complaints?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain?	<input type="checkbox"/>	<input type="checkbox"/>
ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe nose bleeds?	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>
Difficult or painful swallowing?	<input type="checkbox"/>	<input type="checkbox"/>
Oral lesions?	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory

	Y	N
History of asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Other lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing?	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
Productive cough?	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular

	Y	N
Chest pain, pressure or tightness?	<input type="checkbox"/>	<input type="checkbox"/>
Activity or exercise intolerance?	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine

	Y	N
Thyroid disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Heat or cold intolerance?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst or urination?	<input type="checkbox"/>	<input type="checkbox"/>
Blood sugar problems or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
History of osteoporosis or osteopenia?	<input type="checkbox"/>	<input type="checkbox"/>

Hematologic

	Y	N
History of bruising, bleeding, blood clots?	<input type="checkbox"/>	<input type="checkbox"/>

Skin

	Y	N
Changing skin lesions?	<input type="checkbox"/>	<input type="checkbox"/>
Rash?	<input type="checkbox"/>	<input type="checkbox"/>
History of skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Poorly healing skin sores?	<input type="checkbox"/>	<input type="checkbox"/>
Itchy, bleeding, or scabbed lesions?	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal

	Y	N
Black stool?	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool?	<input type="checkbox"/>	<input type="checkbox"/>

	Y	N
Change in bowel habits?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn or acid reflux?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent nausea or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>

Urinary

	Y	N
Blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination?	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent urinary tract infections?	<input type="checkbox"/>	<input type="checkbox"/>

Female

	Y	N
Breast tenderness?	<input type="checkbox"/>	<input type="checkbox"/>
Breast masses?	<input type="checkbox"/>	<input type="checkbox"/>
Changes in self breast exam?	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from nipple?	<input type="checkbox"/>	<input type="checkbox"/>
Skin or contour change?	<input type="checkbox"/>	<input type="checkbox"/>
Breast pain?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal mammogram?	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain or painful intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Possibility of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Risk factors for STD?	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal

	Y	N
Concerning joint pain?	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling?	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>
Gout?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain?	<input type="checkbox"/>	<input type="checkbox"/>
History of fractures?	<input type="checkbox"/>	<input type="checkbox"/>

Neurologic

	Y	N
Concerning headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Significant or new memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
Tingling, numbness?	<input type="checkbox"/>	<input type="checkbox"/>
Gait, balance or coordination problems?	<input type="checkbox"/>	<input type="checkbox"/>
Seizures?	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric

	Y	N
Depression?	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or panic problems?	<input type="checkbox"/>	<input type="checkbox"/>
History of bipolar or manic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia or obsession?	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders?	<input type="checkbox"/>	<input type="checkbox"/>

Allergy

	Y	N
Allergy induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing, runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Scratchy throat, itchy eyes?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 12 months have you had any issues with: having enough food, paying critical bills, housing, accessing care or personal safety? Yes No