Name: ____

Date: ____

Coppell Associates in Family Medicine

Nina Cahan, MD

In preparation for your upcoming physical exam, we are providing you with this questionnaire and ask that it be completed and brought to your scheduled visit.

These answers will assist the physician during your visit and ensure that any areas of concern are addressed at that time.

If you have any questions regarding the questionnaire, please contact our office at 972-393-5559.

Y for 'Yes', N for 'No'

General/Constitutional:

Have you had any of the following? Please answer Y or N and please include any additional information such as how much, how long, mild/moderate/severe, etc.

Change in appetite	Y or N	Chills	Y or N
Fatigue	Y or N	Fever	Y or N
Headache	Y or N	Weight Loss	Y or N
Night Sweats	Y or N	Weight Gain	Y or N
Lightheadedness	Y or N		

Allergy/ Immunology:

Congestion	Y or N
Sneezing	Y or N
Watery Eyes	Y or N

Ophthalmologic:

Blurred vision	Y or N	Decreased visual acuity/clarity of vision	Y or N
Eye discharge	Y or N	Dry eye	Y or N
Flashes of light	Y or N	Floaters in visual field	Y or N
Eye pain	Y or N	Red eye	Y or N

What was the date/approximate date of last vision screen. Date: ___________

ENT:

Blocked ears	Y or N	Ear Pain	Y or N

Decreased hearing	Y or N	Dry mouth	Y or N
Decreased sense of smell	Y or N	Difficulty swallowing	Y or N

What was the date/approximate date of last hearing screen. Date: __________

Endocrine:

Cold Intolerance	Y or N	Excessive Thirst	Y or N
Frequent Urination	Y or N	Heat Intolerance	Y or N
Excessive Sweating	Y or N		

Respiratory:

Cough	Y or N	Shortness of breath at rest	Y or N
Coughing up blood	Y or N	Shortness of breath w/ exertion	Y or N
Blood in phlegm	Y or N	Sputum production	Y or N
Pain with inhalation	Y or N	Wheezing	Y or N

Cardiovascular:

Chest pain at rest	Y or N	Irregular heartbeat	Y or N
Chest pain with exertion	Y or N	Fluid palpitations/increased heart rate	Y or N

Blue coloring of skin around mouth, eye, other areas Y or N

Difficulty lying flat/ needing multiple Pillows at night Y or N

Fluid accumulation/ swelling in legs Y or N

Difficulty breathing with exertion Y or N

Gastrointestinal:

Abdominal pain	Y or N	Blood in stool	Y or N
Change in bowel habits	Y or N	Constipation	Y or N
Do you have daily bowel movements	Y or N	Diarrhea	Y or N
Any exposure to hepatitis	Y or N	Heartburn	Y or N
Vomiting Blood	Y or N	Nausea	Y or N
Rectal bleeding	Y or N	Vomiting	Y or N

Hematology:

Bruising easily	Y or N
Prolonged bleeding	Y or N
Recent transfusion	Y or N

Genitourinary:

Blood in urine	Y or N	Difficulty urinating	Y or N
Frequent urination	Y or N	Pain in lower back	Y or N
Painful Urination	Y or N		

Women Only*:**

Breast lump Y or N Breast pain Y or N Hot flashes Y or N

Discharge from breast	Y or N	Heavy bleeding during menstruation	Y or N
Irregular menses	Y or N	Missed period	Y or N
Painful intercourse	Y or N	Painful menses	Y or N
Vaginal bleeding between periods	Y or N	Vaginal discharge/itching	Y or N

Men Only*:**

Difficulty initiating stream	Y or N	Dribbling after urination	Y or N
Hard testicle/testicles	Y or N	Hernia	Y or N
Hypospadias (opening of penis on underside instead of tip)			Y or N
Lump in groin	Y or N	Penile discharge	Y or N
Rash/Blisters on penis	Y or N	Scrotal pain	Y or N
Scrotal swelling	Y or N	Undescended testicle	Y or N

Musculoskeletal:

Carpal tunnel	Y or N	Joint stiffness	Y or N
Leg cramps	Y or N	Muscle aches	Y or N
Shoulder aches	Y or N	Painful joints	Y or N
Sciatica/pain down leg	Y or N	Swollen joints	Y or N
Trauma to arm/arms	Y or N	Trauma to hip/hips	Y or N
trauma to knee/ knees	Y or N	Trauma to ankle/ankles	Y or N

Peripheral Vascular:

Absent pulses in hands	Y or N	Absent pulses in feet	Y or N
Cold extremities	Y or N	Blanching/paleness of skin	Y or N
Pain/ cramping in legs after exertion	Y or N	Ulcerations/sores on feet	Y or N

Skin:

New lesions	Y or N	Changes to lesions	Y or N
Acne	Y or N	Blistering of skin	Y or N
Eczema	Y or N	Hives	Y or N
Itching of skin	Y or N	Moles	Y or N
Rash	Y or N	Skin cancer	Y or N

Neurologic:

Balance difficulty	Y or N	Coordination difficulty	Y or N
Difficulty speaking	Y or N	Dizziness	Y or N
Fainting	Y or N	Gait/walking abnormality	Y or N
Headache	Y or N	Irritability	Y or N
Loss of strength	Y or N	Tremors	Y or N
Memory loss	Y or N	Seizure	Y or N
Tics	Y or N	Tingling/numbness	Y or N
Loss of vision	Y or N	Loss of use of any extremity	Y or N

Psychiatric:

Anxiety	Y or N	Depressed mood	Y or N
Difficulty sleeping	Y or N	Eating disorder	Y or N
Loss of appetite	Y or N	Mental/physical abuse	Y or N
Stressors	Y or N	Substance abuse	Y or N
Suicidal thoughts	Y or N	Delusions	Y or N
Hearing/seeing hallucinations	Y or N		

Cancer Self-Management:

Do you wear/apply sunscreen Y or N