CLAY
PLATTE
FAMILY
MEDICINE
CLINIC

5501 NW 62nd Terrace, Suite 100, Kansas City, Missouri 64151 (816) 842-4440 • Fax (816) 842-1974

COMPREHENSIVE PHYSICAL EXAMINATION
PATIENT INSTRUCTIONS

For a comprehensive physical examination, your health care provider will review your medical history, perform a thorough physical examination, and will order age-appropriate diagnostic tests.

The time required for the comprehensive physical examination will be 1 to 3 hours. Please remember to complete our medical history form and bring it with you for the physical. Include new information regarding medical illnesses in close family members as well.

Specific laboratory tests will be ordered and must be performed on a "fasting" basis in order to obtain accurate results. This means you may have nothing to eat or drink (except water) after midnight on the day the blood will be drawn.

If you are age 40 or older, a treadmill stress test will be performed by your provider. For this procedure, please wear casual clothing and tennis shoes. It is important not to either smoke or drink coffee prior to having this test done.

Finally, please do not hesitate to contact us if you have any questions regarding your comprehensive physical examination.

IMPORTANT: Not every insurance company pays for annual physical examinations. Please contact your insurance company for verification of coverage for this service. Patients are billed for any services which are not reimbursed by insurance.

#1017 (9/05)

Clay-Platte Family Medicine Clinic, PC

Partnering for Excellence in Health Care 5501 NW 62nd Terrace, Suite 100

ClayPlatteFamily.com Kansas City, MO 64151

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WELL WOMAN EXAM FORM

Patient Name________________________________Age_______LMP__________G____P____A____L____

Check all that apply and complete the following questions:

_____History of abnormal pap _____Extreme menstrual pain _____Painful intercourse
_____Bleeding between periods _____Hot flashes _____Urinary problems
_____Bleeding with intercourse _____Irregular periods _____Vaginal discharge
_____History of breast lumps _____Nipple Discharge _____Vaginal Infections
_____History of genital warts _____History of genital herpes _____History of cervical cancer
_____Family history of ovarian, uterine or breast cancer or osteoporosis (circle those that apply)

Number of sexual partners_____ Sexual preference Male Female (circle those that apply)

Age at menopause________ Age at first period_________ Age at first intercourse__________________

Type of contraception used____

List any previous gynecologic surgeries or procedures____

Are you sexually active?____Do you have concerns about sexually transmitted diseases_____________

Date of last mammogram_____________ Normal Abnormal (circle result of mammogram)

Date of last pap smear_______________ Normal Abnormal (circle result of pap smear)

Date of last bone density test__________ Normal Abnormal (circle result of bone density)

To be completed by provider.

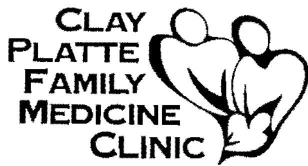
	Normal	**Abnormal**	**Findings**
External Genitalia	________	________	__________________
Vagina	________	________	__________________
Cervix	________	________	__________________
Bimanual Exam	________	________	__________________
Rectal Exam	________	________	__________________
Guiac Stool	________	________	__________________
Breast Exam	________	________	__________________

Assessment _____ Normal Pap and Pelvic Exam
_____ Normal post hysterectomy and pelvic exam

Plan:____

Patient was instructed on self breast exam Initials_____
Patient was instructed on annual mammograms Initials_____

Provider Signature_____________________________ Date____________



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Comprehensive Review of Systems

(To be completed by patient *prior* to Complete Physical)

Name:______________Todays Date:_____ Date of birth:______ Age:____ Sex:__
Marital Status:___No. of children:___Occupation:_________Education level:____________

Please explain any answers in space provided as necessary

General
General Health: □ poor
□ fair
□ good
□ excellent
Exercise per week:_________
Weight loss (past year) _____
Weight gain (past year) _____
□ Fatigue
□ Weakness
□ Fevers
□ Insomnia
□ Snoring
□ Apnea (episodes of stopping breathing during sleep)

Substance Use
Smoking or chewing (amount per day and duration in years):_____________

Alcohol consumption (avg drinks/week):_____________

Caffeine (type/quantity per day):_______________

Recreational/Street drugs:_________________________

Eyes
Last eye exam:_____
□ Glasses
□ Contacts
□ Change in vision
□ Eye pain
□ Redness
□ Excessive tearing
□ Double vision
□ Blurred vision
□ Spot/specks/floaters
□ Flashes
□ Glaucoma

Head/Ears
□ Headaches
□ Past significant head injury
□ Hearing loss
□ Ringing of ears
□ Earaches or ear pain
□ Recurrent ear infections
□ Ear drainage
□ Hearing aids

Nose/Sinus/Throat/Neck
□ Frequent colds
□ Nasal congestion or drainage
□ Allergies/hay fever
□ Nosebleeds
□ Chronic Sinusitis
□ Dental problems
□ Gum bleeding/pain/swelling
□ Dentures
□ Tongue or mouth pain./soreness
□ Dry mouth
□ Mouth or lip sores or ulcers
□ Hoarseness
□ Neck lumps or masses
□ Neck pain or discomfort

Last dental exam:________

Respiratory
Last chest x-ray or CT scan of chest:_______________

Date of last Pneumonia vaccine (pneumovax):___________

□ Cough
□ Coughing up blood
□ Shortness of breath at rest
□ Shortness of breath with exercise or exertion
□ Wheezing
□ Asthma or previous history of asthma
□ Chronic or recurrent bronchitis
□ History of pneumonia
□ History of tuberculosis
□ Pleurisy

Cardiac
Previous stress test or heart catheterization:____________

□ Known heart disease
□ Hypertension/High blood pressure
□ History of Rheumatic fever
□ Heart murmur
□ Chest pain
□ Chest tightness/pressure/discomfort
□ Palpitations
□ Fluttering or racing of heart
□ Swelling or edema
□ Wake from sleep short of breath
□ Shortness of breath

Gastrointestinal
Date of last Colonoscopy:__________

□ Difficult/painful swallowing
□ Heartburn/acid reflux/indigestion
□ Change in appetite
□ Nausea/vomiting
□ Stomach ulcers
□ Rectal bleeding
□ Black or tarry stools
□ Constipation
□ Diarrhea
□ Change in bowel movements
□ Abdominal pain
□ Abdominal bloating or distension
□ Hepatitis
□ Gall bladder problems

Male Urogenital
□ Frequent urination
□ Painful urination
□ Night-time urination
□ Urinary hesitancy
□ Prostate problems
□ Prostate cancer
□ Leakage of urine/incontinence
□ Blood in urine
□ Kidney stones
□ Penile discharge
□ Testicular pain
□ Testicular lump or mass
□ Penile rashes, sores, or growths
□ History of STD
□ Erectile dysfunction
□ Loss of sexual interest of libido
□ Ejaculatory dysfunction

Female Urogenital	Breast	Vascular
Last pap smear:_____ Age when menses started:______ Number of pregnancies:_____ Number of live births:______ Current contraception:________ Age of menopause:___________ □ Abnormal pap smear □ Irregular periods □ Painful periods □ Bleeding between periods □ Pain with intercourse □ Pelvic pain □ Postmenopausal bleeding □ Vaginal discharge □ History of STD □ Loss of sexual interest/libido □ Urine leakage/incontinence □ Urinary frequency □ Pain with urination □ Kidney stones □ Blood in urine	Date of last Mammogram:_________ □ Abnormal mammogram □ Breast pain □ Breast lumps or masses □ Nipple discharge □ Breast skin discoloration □ Previous breast biopsy **Musculoskeletal** □ Joint pains: If yes, which joints: ______ □ Joint stiffness □ Joint swelling □ Arthritis □ Gout □ Back Pain □ Muscle pain □ Muscle weakness	□ Known vascular disease □ Claudication (pain in legs with physical activity that is relieved with rest) □ Leg cramps □ Varicose veins □ Cold extremities □ Poor circulation □ Carotid artery stenosis **Hematological** □ Anemia □ Blood transfusion □ Easy/excessive bruising □ Leukemia □ Any known blood disorder □ Enlarged lymph nodes
Neurological	**Endocrine**	**Allergy/Immunologic**
□ Fainting spells □ Blackout spells □ Seizures □ Weakness □ Paralysis □ Tremor/shakiness □ Numbness/tingling/loss of feeling □ Involuntary movements □ Memory loss □ Confusion □ Temporary loss of vision □ Incoordination □ Gait or balance disturbance	□ Diabetes □ Previous abnormal blood sugar test □ Thyroid problems □ Heat intolerance □ Cold intolerance □ Excessive sweating □ Excessive thirst □ Frequent urination □ Fatigue **Psychiatric** □ During the past month have you often been bothered by feeling down, depressed, or hopeless? □ During the past month, have you been bothered by little interest or pleasure in doing things? □ Depression □ Anxiety □ Obsessive compulsive disorder □ ADD/ADHD □ Nervousness □ Panic or anxiety attacks □ Bipolar disorder □ Suicidal thoughts	Date of last Tetanus Shot:_________ □ Previous serious allergic reaction □ Seasonal allergies □ Asthma □ Eczema/atopic dermatitis □ Known allergic reaction to anything in past:_______________ □ Hives □ HIV **Skin** □ Previous skin cancer: Location:_____ Type of skin cancer:__________ □ Rashes □ Worrisome moles □ Lumps □ Sores □ Itching □ Discoloration

Please List any other health concerns not addressed above or any other information pertinent to your health

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Patient Signature:______________________________ Date:___/___/___

Provider (Physician/Physician assistant/Nurse practitioner) initials:__________