Lakeview Clinic

Name:_____ **Date of Birth:** _____

Pharmacy:_____ **Today's Date:** _____

Please answer the following questions to help us complete your physical.

Do you need any medications refilled today? ____Yes ____No
Any surgeries, hospitalizations, or other procedures since your last visit? ____Yes ____No
Are you currently enrolled in the Patient Portal? ____Yes ____No

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In general, would you say your health this past year has been: Good Fair Poor

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Do you see the dentist at least yearly? ____Yes ____No
Do you have any vision problems? ____Yes ____No
Do you wear glasses and/or contacts? ____Yes ____No
Do you have regular eye exams? ____Yes ____No
Do you have difficulty with your hearing? ____Yes ____No

Would you say that you have a healthy diet? ____Yes ____No
Do you have any concerns about your weight? ____Yes ____No
Do you exercise regularly? ____Yes ____No
Do you currently/have you ever used any tobacco? ____Yes ____No
If yes, please circle which of the following applies to you:
cigarettes cigars pipe e-cig smokeless tobacco former tobacco user
Do you drink alcohol? ____Yes ____No
If yes, how many drinks per day? _____ per week? _____ per month? _____
Do you use any illicit/recreational drugs? ____Yes ____No

In the past 2 weeks, have you found little interest or pleasure in doing things? ____Yes ____No
In the past 2 weeks, have you felt down, depressed, or hopeless? ____Yes ____No

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Females:

Do you have regular periods? ____Yes ____No
Any problems with your periods? ____Yes ____No
Are you sexually active? ____Yes ____No
If yes, do you do anything to prevent pregnancy?
What type of contraception do you use?
Have you ever been pregnant? ____Yes ____No
If yes, how many total pregnancies have you had? _____
How many live births? _____

Males:

Are you sexually active? ____Yes ____No
If yes, do you do anything to prevent pregnancy?
What type of contraception do you use?
Do you experience erectile dysfuction? ____Yes ____No

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General Health: Are you having any of the following symptoms/problems

General	☐ None	☐ fever	☐ malaise	☐ anorexia	☐ chills	☐ fatigue
Head	☐ None	☐ facial pain	☐ facial pressure			
Eyes	☐ None	☐ pain	☐ drainage	☐ itchy	☐ redness	☐ blurred vision
Ears/Nose/Throat	☐ None	☐ earache	☐ sore throat	☐ hearing loss	☐ nasal drainage	☐nasal congestion
Chest	☐ None	☐ chest pain	☐ racing heart	☐ lightheaded	☐ irregular heartbeat	☐
Lungs	☐ None	☐ cough	☐ sputum	☐ wheezing	☐ short of breath	
Stomach	☐ None	☐ pain ☐ blood	☐ nausea ☐ cramps	☐ constipation ☐ diarrhea	☐ bloating ☐ heartburn	☐ vomiting
Urinary	☐ None	☐ pain	☐ frequency	☐ urgency	☐ blood	
Muscles	☐ None	☐ joint pain	☐ joint swelling	☐ back pain	☐ back spasms	☐ weakness
Skin	☐ None	☐ rash	☐ changing mole			
Neurologic	☐ None	☐ headache ☐ falling	☐ dizziness	☐ fainting	☐ Persistent numbness	☐ persistent weakness
Psychiatric	☐ None	☐ insomnia	☐ anxiety	☐ suicidal thoughts	☐ irritable	☐ depression
Endocrine	☐ None	☐ hot flashes ☐ excessive thirst	☐ night sweats	☐ breast mass	☐ intolerance to cold	☐ intolerance to heat
Hematologic	☐ None	☐ easy bleeding	☐ jaundice	☐ easy bruising	☐ swollen glands	

Do you have any other health concerns?