Date: / /

Robert K. Dyo, M.D.

Annual Physical Information Form

NAME:_____ **DOB:**_____ **SEX:** _____ **MARITAL STATUS: M S D W**

ADDRESS OR PHONE NUMBER CHANGE? Y / N _____

1. What is the reason for your visit today? _____

2. Are there any other problems bothering you? _____

Past Medical History:

3. **Surgeries**

TYPE	DOCTOR	DATE

Serious Injuries, broken bones, etc.

Allergies _____

Recent immunizations with dates _____

Childhood diseases _____

Family History:

4.	Age	State of Health	If Not Living: Age at Death	Cause
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				
Spouse				

Does anyone in your family have tuberculosis, diabetes, heart disease, cancer, or kidney disease?

Personal History:

5. Amount of coffee daily?_____
   Amount of smoking daily?_____ For how many years?_____

Date: / /

Robert K. Dyo, M.D.

Amount of alcohol daily?_____ For how many years?_____
Your occupation: _____
Last colonoscopy: _____
Last stress test: _____
Special religious concerns: _____

6. Current Medication (if you have a list please attach):_____
_____

Do you now, or have you recently had any of the following?

7. Headaches _____ Hearing Loss_____ Toothache _____
Head Injury _____ Dizziness_____ False Teeth _____
Eye Pain _____ Drainage from nose_____ Dental Work _____
Swollen/Red Eyes _____ Nose Bleed_____ Sore Throat _____
Visual Disturbance _____ Colds_____ Difficulty Swallowing_____
Do you wear glasses/contacts _____ Sinus Pain_____ Hoarseness _____
Ear Ache _____ Loss of sense of smell_____ Speech Difficulty _____
Ear Drainage _____ Sores in mouth_____ Stiffness or pain in neck_____
Ringing in ears _____ Painful or bleeding gums_____ Joint pain _____
8. Skin trouble/rash? _____
9. Coughing up sputum? _____ Wheezing _____ Chills _____
Night Sweats _____ Pain in chest while coughing or deep breathing? _____
10. Rapid Heart Beat _____ Chest Pain _____
Irregular Heart Beat _____ Swelling of feet, arms or abdomen _____
Shortness of breath _____ Skin turns blue _____
With exercise _____ Fainting _____
Without exercise _____ Fatigue _____
Lying flat in bed _____ Insomnia _____
11. Increased appetite _____ Black bowel movements _____
Loss of appetite _____ Abdominal pain _____
Excess gas _____ Weight loss _____
Belching _____ Weight gain _____
Nausea _____ Jaundice _____
Vomiting _____ Change in bowel movements _____
Bloody bowel movements _____ Unusual thirst _____
Diarrhea _____ Constipation _____
12. Burning on urination _____ Loss of control of urine _____
Frequent urination _____ Bloody urine _____
How many times per day _____ Cloudy urine _____
Difficulty urinating _____ Abnormal urine volume _____
Urination at night _____
Changes in sexual interest _____ Do you have any questions in this area? _____
13. Convulsions _____ Tingling_____ Numbness _____
Hearing sounds _____ Difficulty walking _____ Paralysis_____
Seeing visions _____ Dizziness_____ Sadness _____
Loss of interest in work or hobbies? _____ Suicidal thoughts_____ Crying Spells _____

FEMALES

Age when menstrual cycle began _____ Vaginal discharge_____ No. of pregnancies _____
Duration of periods _____days Scant periods_____ No. of living children _____
Interval between periods _____ days Heavy periods_____ No. of miscarriages _____
Periods – Regular_____ Irregular_____ Bleeding between periods_____
Date of last menstrual cycle _____ Do you take birth control pills?_____
Date of last Pap smear _____ Normal_____ Abnormal _____
Age of menopause _____ Bleeding since menopause_____
Date of last Mammogram _____ Normal_____ Abnormal _____