Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________

Annual Physical Questionnaire

List below names of all current doctors:

Name of Doctor	Specialty	Name of Doctor	Specialty

Have you been to the Emergency Room or Hospital in the last year? If so, please provide details:

Date	Hospital/ER	Reason for Admission

Has any of your immediate family had any health changes? [ ] Yes [ ] No

If yes, explain: ______________________________

Has your mood changed? [ ] Yes [ ] No

Do you ever feel worried, anxious, or sad? [ ] Yes [ ] No

Are you sexually active? [ ] Yes [ ] No

Please check all that apply: [ ] One Partner [ ] Multiple Partners [ ] With Women [ ] With Men [ ] Both

If you were born between 1945 and 1965, have you been tested for Hepatitis C? [ ] Yes [ ] No

When was your last:

For	Screening	Date	For	Screening	Date
All	For all:		Women	Mammogram	
	Colonoscopy			Pap smear	
	Glaucoma screening			Bone Density (DEXA)	
Men	PSA—Prostate levels		Men	PSA	
Smokers	Lung Cancer Screening		Men who have smoked	Abdominal Aortic Aneurysm Screening	

Immunizations:

	Date		Date
Tetanus (Td or TDAP)		Pneumonia (Prevnar13/Pneumovax23)	
Flu (Influenza)		Shingles (Shingrix)	

Do you have a Living Will or Advance Directive? *If yes, please bring a copy with you* [ ] Yes [ ] No