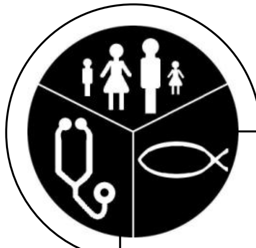
Geauga Family Physicians

Board Certified Family Physicians



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Adult Physical Form · Please complete BEFORE your appointment

Physicals require a urine specimen given at the office and possibly fasting blood work (nothing to eat or drink except water for 12 hours). We require a 48 hour notice of cancellation. There is a $50.00 fee for a missed physical appointment. Physicals may need to be completed at a second appointment if the doctor identifies concerns that need to be addressed at the time of your physical.

Date: ________________________________ Name: ____

Please complete the following questionnaire to the best of your ability by marking (X) in the appropriate *Yes* or *No* columns. Please fill out the form carefully and neatly and bring it with you when you come for your appointment.

	Yes	No
Do you have:		
(1) A problem with your eyes which is not corrected by glasses?	☐	☐
(2) Frequent stuffy or watery nose or sneezing?	☐	☐
(3) Difficulty hearing?	☐	☐
(4) Other ear problems?	☐	☐
Are you troubled by:		
(5) Asthma, or notice yourself wheezing?	☐	☐
(6) A frequent cough?	☐	☐
(7) Shortness of breath?	☐	☐
Have you ever:		
(8) Coughed up blood (coughed, not vomited)?	☐	☐
(9) Been treated for TB or other chest disease?	☐	☐
Do you have or have you been told you had:		
(10) High blood pressure?	☐	☐
(11) Any type of heart disease?	☐	☐
(12) Heart murmur?	☐	☐
Do you ever have:		
(13) Chest pains or heavy pressure in your chest with exertion?	☐	☐
(14) Leg pains from walking rapidly or walking uphill?	☐	☐
(15) Episodes of fast heart beating or skipped beats (palpitations)?	☐	☐
(16) Varicose veins?	☐	☐
Do you have or are you troubled by:		
(17) Difficulty swallowing foods or liquids?	☐	☐
(18) Abdominal pains?	☐	☐
(19) Frequent indigestion or heartburn?	☐	☐
(20) Constipation?	☐	☐
(21) Diarrhea or frequent loose bowels?	☐	☐
Has there been a definite change:		
(22) In your weight in recent months?	☐	☐
(23) In the pattern of your bowel movements in the past year?	☐	☐
Have you ever had or been told you had:		
(24) An ulcer?	☐	☐
(25) Black (like tar) bowel movements?	☐	☐
(26) Yellow jaundice, hepatitis, or any type of liver trouble?	☐	☐
(27) Gallstones or gallbladder problems?	☐	☐
(28) Any stomach or intestinal problems?	☐	☐
Have you ever:		
(29) Vomited blood?	☐	☐
(30) Has blood in your bowel movements (not just on the paper)?	☐	☐
(31) Been anemic or been treated for any blood problems?	☐	☐
(32) Had sickle cell trait or anemia?	☐	☐
(33) Been refused as a blood donor?	☐	☐

Have you had or do you have:

		Yes	No
(34)	Problems with your kidney, bladder, or prostate?	☐	☐
(35)	Loss of control of your urine?	☐	☐
(36)	Pain or burning when you urinate?	☐	☐
(37)	Blood in your urine?	☐	☐
(38)	Trouble starting the flow of your urine?	☐	☐
(39)	To repeatedly get up at night to urinate?	☐	☐
Have you been treated for or told you had:			
(40)	Venereal disease?	☐	☐
Do you have:			
(41)	Any skin problems?	☐	☐
(42)	Diabetes?	☐	☐
(43)	Thyroid disease?	☐	☐
Are you troubled by:			
(44)	Frequent back pain?	☐	☐
(45)	Pain or swelling around your joints?	☐	☐
Have you ever:			
(46)	Broken any bones?	☐	☐
Are you troubled by:			
(47)	Frequent headaches?	☐	☐
(48)	Attacks of dizziness?	☐	☐
Have you ever:			
(49)	Had seizures, convulsions, or fits?	☐	☐
(50)	Temporarily lost control of a hand or foot?	☐	☐
(51)	Had a stroke or been paralyzed?	☐	☐
(52)	Temporarily lost your ability to speak?	☐	☐
(53)	Fainted or lost consciousness for no obvious reason?	☐	☐

Have you ever had:

		Yes	No
(54)	Hallucinations (seen or heard things that were not really there?)	☐	☐
(55)	Much trouble with nervousness?	☐	☐
(56)	To take medication for your nerves?	☐	☐
(57)	Frequent trouble falling asleep or staying asleep?	☐	☐
(58)	Do you often feel tired, even after a good night's sleep?	☐	☐
(59)	Do you often feel "down in the dumps" or depressed?	☐	☐
(60)	Do you often feel like crying without any reason?	☐	☐
(61)	Do you think that you may be using alcohol excessively?	☐	☐
(62)	Do you use street drugs?	☐	☐
(63)	Have you ever had any medical problems not mentioned here which are worrying you?	☐	☐

Describe: ______________________________

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Pre-Menopausal Women:

(64) What was the date of your last menstrual period? ________________

(65) How often do you menstruate? ________

____

(66) What type of birth control do you use?

____

		Yes	No
(67)	Vaginal bleeding between your periods?	☐	☐
Women: Have you had …			
(68)	Vaginal bleeding following the stopping of your menstrual periods (after menopause)?	☐	☐
(69)	A noticeable lump in your breast of discharge from your nipples?	☐	☐