VonStieff MEDICAL GROUP

Annual Physical Form

General Information

Name				
Birth Date	Phone	Email Address		
Street Address				
City			State	Zip

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender

☐ Male ☐ Female

Employment Information

Position	Employer	Phone	
Employer's Address			
City		State	Zip

Present Medical History

Check the box for any questions that you answer YES to. If your answer is NO, do not check the box.

- ☐ Has a doctor ever said that your blood prerssure is/was too high?
- ☐ Do you ever have pain in your chest or heart?
- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race?
- ☐ Do you ever notice extra heart beat or skipped beats?
- ☐ Are your ankles often badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have, or have had, heart trouble, an abnormal electrocardiogram ECG or EKG), heart attack, or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Do you sometimes get out of breath when sitting or sleeping?
- ☐ Has a doctor ever told you that your cholesterol level is/was high?
- ☐ Has a doctor ever told you that you have an abdominal aortic aneurysm?
- ☐ Has a doctor ever told you that you have critical aortic stenosis?

Comments: _____

_____

_____

_____

Do you now have, or have you recently experienced, any of the following:
Check the box for any questions that you answer YES to. If your answer is NO, do not check the box.

- ☐ Chronic, recurrent or morning cough?
- ☐ Episode of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen or painful knees or ankles?
- ☐ Swollen, stiff, or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation, or diarrhea?
- ☐ Significant vision or hearing problems?
- ☐ Recent change in a wart or a mole?
- ☐ Glaucoma or increased pressure in the eyes?
- ☐ Exposure to loud noises for long periods?
- ☐ An infection, such as pneumonia, accompanied by a fever?
- ☐ Significant, unexplained weight loss?
- ☐ A fever, which can cause dehydration and rapid heart beat?
- ☐ A deep vein thrombosis (blood clot)?
- ☐ A hernia that is causing symptoms?
- ☐ Foot or ankle sores that won't heal?
- ☐ Persistent pain or problems walking after you have fallen?
- ☐ Eye conditions, such as bleeding in the retina or detached retina?
- ☐ Cataract or lens transplant?
- ☐ Laser treatment or other eye surgery?

Comments: _____

_____

_____

_____

Women only answer the following:

- ☐ Menstrual period problems?
- ☐ Significant childbirth-related problems?
- ☐ Urine loss when you cough, sneeze, or laugh?

Date of last pelvic exam and/or Pap smear: / /
Are you on any type of hormone replacement therapy? ☐ Yes ☐ No

Men and women answer the following:

List any prescriptions, self-prescribed medications, dietary supplements, or vitamins you are now takig:

Date of last complete physical examination: / /
The result was: ☐ Normal ☐ Abnormal ☐ I can't remember ☐ I have never had one

Date of last chest x-ray: / /
The result was: ☐ Normal ☐ Abnormal ☐ I can't remember ☐ I have never had one

Date of last electrocardiogram (ECG or EKG): / /
The result was: ☐ Normal ☐ Abnormal ☐ I can't remember ☐ I have never had one

Date of last dental checkup: / /
The result was: ☐ Normal ☐ Abnormal ☐ I can't remember ☐ I have never had one

List any other medical or diagnostic test you've had in the past two years:

List surgeries and hospitalizations, including dates and reasons:

List any drug allergies:

Past Medical History

Check the box for any questions that you answer YES to. If your answer is NO, do not check the box.

- ☐ Heart attack
  If yes, how many years ago:
- ☐ Reumatic Fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood sugar tests
- ☐ Phlebitis (inflamation of a vein)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Scarlet Fever
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Astma
- ☐ Abnormal chest x-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs, or joint

Past Medical History (continued)

- ☐ Stroke
- ☐ Diptheria
- ☐ Broken bones
- ☐ Jaundice or gall bladder problems

Family Medical History

My father is:

☐ Alive, his current age is: _____ ☐ Deceased, age at the time of his death was: _____

If alive, how is his general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If his health is poor, why? _____

My mother is:

☐ Alive, her current age is: _____ ☐ Deceased, age at the time of her death was: _____

If alive, how is her general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If her health is poor, why? _____

Siblings:

Number of brothers: _____ Number of sisters: _____ Age range: _____

Health problems:

_____

_____

Family Diseases

Have any of your blood-relatives had any of the following (include grandparents, aunts, and uncles. Do no include cousins, relatives by marriage, and half-relatives)?

Check the box for any questions that you answer YES to. If your answer is NO, do not check the box.

- ☐ Heart attack, under the age of 50
- ☐ Stroke, under the age of 50
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ☐ Diabetes
- ☐ Asthma or hay fever
- ☐ Congenital heart disease (existing at birth but not hereditary)
- ☐ Heart operations
- ☐ Glaucoma
- ☐ Obesity (20 or more pounds overweight)
- ☐ Leukemia or cancel, under the age of 60

Comments: _____

_____

_____

_____

Other Heart Disease Risk Factors

Smoking

Have you ever smoked cigarettes, cigars, or a pipe? ☐ Yes ☐ No (if no, skip to diet section)
If you currently, or used to, smoke cigarettes, how many per day? _____ What age did you start? _____
If you currently, or used to, smoke cigars, how many per day? _____ What age did you start? _____
If you currently, or used to, smoke pipes how many per day? _____ What age did you start? _____
If you stopped smoking, when did you stop? _____
If you currently smoke, when did you start? _____

Diet

What do you consider a good weight for you? _____
What is the most you have ever weighed? _____ What age were you? _____
My current weight is: _____ One year ago, my weight was: _____
When I was 21, my weight was: _____
Number of meals you usually eat per day: _____

Number of times per week you usually eat the following:
Beef: _____ Fish: _____ Desserts: _____ Glasses of water: _____
Pork: _____ Fowl: _____ Fried foods: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No
If yes, how often? Beer: ☐ Occasionally ☐ Often ☐ Never
Wine: ☐ Occasionally ☐ Often ☐ Never
Hard liquor: ☐ Occasionally ☐ Often ☐ Never

Comments: _____

_____

_____

_____

Fred J. VonStieff, M.D. • Kristi M. Carpenter, D.O.
2481 Pacheco Street, Concord, CA 94520 • Ph. (925) 680-8933 • Fax (925) 680-7635
Please visit us online at www.vsmedicalgroup.com