



Family Works

5604 Medical Circle
Madison, Wisconsin 53719

PHYSICAL EXAM QUESTIONNAIRE

Name: _____

DOB: _____

Physician: _____

Date: _____

Clinic Name: _____

Address: _____

Intake Questions

- | | | | | |
|----|---|-----|-----|---------|
| 1. | Have you ever had or do you presently have: | yes | no | refused |
| | Asthma | ___ | ___ | ___ |
| | Bedwetting | ___ | ___ | ___ |
| | Chicken Pox | ___ | ___ | ___ |
| | Diabetes | ___ | ___ | ___ |
| | Epilepsy | ___ | ___ | ___ |

2. Are you taking any medications? ___ ___ ___
- explain: _____
- _____

3. Do you have any allergies? ___ ___ ___
- explain: _____
- _____

4. Have you been in contact with any of the following contagious illnesses in the past 4 weeks: Chicken Pox, Strep Throat or Hepatitis? ___ ___ ___
- explain: _____
- _____

5. Have you ever had a sexually transmitted disease? ___ ___ ___
explain: _____

6. Have you ever had any genital discharge/drainage? _____

7. Have you ever had any problems with or injuries to your:

	yes	no	refused		yes	no	refused
Back	___	___	___	Hips	___	___	___
Neck	___	___	___	Knees	___	___	___
Feet	___	___	___	Ankles	___	___	___

Females:

Are you now or have you ever been pregnant? _____

Have you ever had a pap or pelvic exam? _____

Conclusions from Exam

Restrictions: _____

Medications: _____

Follow-up (please note if a follow-up appointment/treatment is necessary):

Recommendations: _____

Physician's Signature: _____

Date: _____

Review of Systems and Physical Exam

Ht. _____ Wt. _____ BP _____ P _____ Temp _____

Exam

Notes

	normal	abnormal
general appearance		
skin/nails/hair		
eyes/fundi		
head/scalp		
ears		
nose		
mouth/pharynx/tonsils		
neck/thyroid		
nodes		
chest		
lungs		
breasts		
heart		
abdomen		
back		
genitalia		
tanner stage		
extremities		
neurological		
ano.-rectal		
knees		
ankles		
feet		
other		