Lakeview Clinic Ltd

Name: _____ Date of Birth: _____

Pharmacy: _____ Today's Date: _____

Please answer the following questions to help us complete your physical.

In general, would you say your health this past year has been:	Good	Fair	Poor

Do you see the dentist at least yearly?	____Yes ____No
Do you have any vision problems?	____Yes ____No
Do you have difficulty with your hearing?	____Yes ____No
Would you say that you have a healthy diet?	____Yes ____No
Do you have any concerns about your weight?	____Yes ____No
Do you exercise regularly?	____Yes ____No
Do you currently or have you ever used any tobacco?	____Yes ____No
Do you drink alcohol?	____Yes ____No
Do you use any illicit drugs?	____Yes ____No
Do you use Marijuana or CBD oils/gummies?	____Yes ____No

Females:

Do you have any menstrual problems?	____Yes ____No
Are you sexually active?	____Yes ____No
Do you use any kind of contraception?	____Yes ____No
Have you ever been pregnant?	____Yes ____No

Males:

Are you sexually active?	____Yes ____No
Do you use any kind of contraception?	____Yes ____No
Do you experience erectile dysfunction?	____Yes ____No

Do you need any medications refilled today?	____Yes ____No
Any surgeries, hospitalizations, or other procedures since your last visit?	____Yes ____No

Continue on other side

Lakeview Clinic

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General Health: Are you having any of the following symptoms/problems? If so, please circle.

General	None	Fever	Malaise	Anorexia	Chills	Fatigue
Head	None	Facial Pain	Facial Pressure			
Eyes	None	Pain	Drainage	Itchy	Redness	Blurred Vision
Ears/Nose/Throat	None	Earache	Sore throat	Hearing loss	Nasal drainage	Nasal congestion
Chest	None	Pain	Racing Heart	Lightheaded	Irregular Heartbeat	
Lungs	None	Cough	Sputum	Wheezing	Short of breath	
Stomach	None	Pain Cramping	Nausea Diarrhea	Constipation Heartburn	Bloating Blood	Vomiting
Urinary	None	Pain	Frequency	Urgency	Blood	
Muscles	None	Joint Pain	Joint swelling	Back Pain	Back Spasms	Weakness
Skin	None	Rash	Changing Mole			
Neurologic	None	Headache	Dizziness	Fainting Falling	Persistent Numbness	Persistent Weakness
Psychiatric	None	Insomnia	Anxiety	Suicidal thoughts	Irritable	Depression
Endocrine	None	Hot Flashes	Night sweats	Breast Mass	Intolerance to cold/heat	Excessive thirst
Hematologic	None	Jaundice	Easy bleeding	Easy bruising	Swollen glands	

Do you have any other health concerns?