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

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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/have you ever used any tobacco?	____Yes	____No
Do you drink alcohol?	____Yes	____No
Do you use any illicit/recreational drugs?	____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

In the past 2 weeks, have you found little interest or pleasure in doing things?	____Yes	____No
In the past 2 weeks, have you felt down, depressed, or hopeless?	____Yes	____No

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Do you need any medications refilled today?	____Yes	____No
Any surgeries, hospitalizations, or other procedures since your last visit?	____Yes	____No
Are you currently enrolled in the Patient Portal?	____Yes	____No

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Name:_________________________________ **Date of Birth:** ___________________

General Health: Are you having any of the following symptoms/problems

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	☐ chest pain	☐ racing heart	☐ lightheaded	☐ irregular heartbeat	☐
Lungs	☐ None	☐ cough	☐ sputum	☐ wheezing	☐ short of breath	
Stomach	☐ None	☐ pain ☐ blood	☐ nausea ☐ cramps	☐ constipation ☐ diarrhea	☐ bloating ☐ heartburn	☐ 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 ☐ falling	☐ dizziness	☐ fainting	☐ Persistent numbness	☐ persistent weakness
Psychiatric	☐ None	☐ insomnia	☐ anxiety	☐ suicidal thoughts	☐ irritable	☐ depression
Endocrine	☐ None	☐ hot flashes	☐ night sweats ☐ excessive thirst	☐ breast mass	☐ intolerance to cold	☐ intolerance to heat
Hematologic	☐ None	☐ jaundice	☐ easy bleeding	☐ easy bruising	☐ swollen glands	

Do you have any other health concerns?

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