

Guide to your Annual Exam

Have you had any major illnesses or surgeries in the past year? _____

Have you had any new illness or deaths in your family over the last year? _____

How much have you been...

Exercising: _____

Smoking: _____

Using alcohol: _____

Circle all of the your symptoms you have had over the last three months. Below describe any symptoms in detail

General	Sensory	Head&Neck	Chest & Lungs	Genital & Urinary	Stomach	Muscle & Skeleton	Psychiatric
Fatigue	Visual changes	Runny nose	Chest pain, tightness or pressure	Burning on Urination	Nausea	Joint pain	Depression
Weight loss	Double vision	Nasal congestion	Shortness of breath	Urinary frequency	Vomiting	Stiffness	Anxiety
Weight gain	Blurred vision	Sore throat	Difficulty breathing when lying down	Urinary urgency	Diarrhea	Swelling	Hallucinations
Not hungry	Decreased hearing	Headache	Cough	Urinary hesitancy	Constipation	Weakness	Delusions
Difficulty sleeping	Numbness	Tooth pain	Coughing up blood	Blood in urine	Blood in stool		Memory loss
Falls	Tingling	Facial pain	Shortness of breath on exertion	A lot of urinating at night	Change in appetite		Confusion
Skin problems	Dizziness	Difficulty chewing	Palpitations or irregular heart beat	Urinary incontinence			
	Headache	Difficulty swallowing					

Men	Women
Pain or lumps in your testicles	Breast changes
Any sexual dysfunction/ability to get or maintain an erection	Menstrual changes
	Vaginal Discharge/bleed
	Pain with intercourse

Describe in detail any symptoms circled above:

Social Questions:

- | | | |
|--|---|---|
| 1. Have you had any changes in living arrangement? | Y | N |
| 2. Have you had any change in relationships? | Y | N |
| 3. Have you had any changes in your finances? | Y | N |
| 4. Have you had a decreased ability to perform activities of daily living? | Y | N |

Describe: _____

Depression Screen

- | | | |
|--|---|---|
| 1. Do you feel depressed, sad or blue? | Y | N |
| 2. Have you lost interest in many activities you previously enjoyed? | Y | N |
| 3. Do you have problems sleeping? | Y | N |
| 4. Do you suffer from lack of energy? | Y | N |
| 5. Are you frequently unable to concentrate? | Y | N |
| 6. Have you had any appetite changes? | Y | N |
| 7. Do you frequently feel irritable, restless, anxious or withdrawn? | Y | N |
| 8. Do you feel bad about yourself or have a lot of guilt? | Y | N |
| 9. Do think you things would be easier if you were dead? | Y | N |
| 10. Do you ever think about killing yourself? | Y | N |

Describe: _____

For Older Adults

Check the column that best describes your ability to do the following activities.

	Independent	Some help	Heavy assistance	Complete Dependence
Bathing				
Toileting				
Walking				
Dressing				
Grooming				
Feeding				
Managing Money				
Handyman work				
Taking medications				
Getting around town				
Laundry				
Housekeeping				
Meals				
Shopping				
Using the telephone				

Questions to ask your health care provider

1. Are all of my medicines necessary?
2. Do I need any routine labs such as blood counts, kidney function tests, diabetes tests, cholesterol tests or thyroid tests (refer to the preventative health care worksheet)?
3. Do I need any diagnostic tests such as a mammogram, tests for colon cancer, EKG or bone density tests (refer to the preventative health care worksheet)?
4. Are there any unusual findings on my exam?
5. Do I need a pelvic, breast or prostate exam?
6. Do I need any vaccinations?
7. Can you give me any advice about lifestyle modifications that will make me healthier?