WOODS FAMILY MEDICINE

ABBEY L. WOODS, MD

HEALTH MAINTENANCE/PHYSICAL FORM:

Patient's Name: _____ Date of Birth: _____

Any new medications since last visit? NO/ YES (explain) _____

Any specialist visit, ER, or hospitalization since last visit: NO/ YES (explain) _____

Any falls since last visit? NO/YES _____

Review of Systems:			
Over the last 2 weeks have you had any of the following: (circle)			
☐ Headache	☐ Blurry or double vision	☐ Nasal discharge/bleeding	☐ Trouble swallowing
☐ Lumps or bumps in neck	☐ Hoarseness	☐ Ear pain	☐ Ringing in ears
☐ Cough	☐ Chest pain	☐ Shortness of breath	☐ Palpitations (heart racing)
☐ Stomach pain	☐ Change in bowel habits	☐ Blood in urine or stool	☐ Numbness or tingling in hands or feet
☐ Fever	☐ Weakness	☐ Dizziness	☐ Leg swelling

Social History			
Tobacco Use:	Current Use (how much)	Former Use (quit date)	Never used ☐
Nicotine Use:	Chew/Snuff/Dip?	E-cigarette Use?	Other nicotine supp? ☐
Alcohol Use:	_____drinks/week	Beer/Wine/Liquor	Never used ☐
Drug Use:	Yes, type:		Never used ☐

Preventative History (ONLY need to list NEW information since last physical with Woods Family Medicine)	
Immunizations: (month/year) Tdap: _____ PCV 13: _____ PCV 23: _____ Shingles:_____	Colonoscopy: Date: _____ Where: _____ Results:_____
Last STD screening date: _____	Lung Cancer Screening: Date: _____ Where: _____ Results:_____
WOMEN	MEN
Mammogram: Date: _____ Where: _____ Results:_____	Prostate Cancer Screening: Date: _____ Results:_____
Bone density screening: Date: _____ Where: _____ Results:_____	
PAP testing: Date: _____ Where: _____ Results:_____	