Physical Examination Questionnaire

Your Name: _____

Please describe the health issues you want to discuss at your Physical Examination Office Visit.
Then please label them with a "1", "2", "3", etc. based on the importance of the issue to you.
Feel free to use the other side of the page if you'd like.
(Please note: we don't save this paper questionnaire. We use it to guide the conversations that you'll have with Dr B and the staff. It then gets shredded.)

Background Information

Where were you born?

Where did you spend most of your childhood?

Did you have any health issues during your childhood through high school that you consider to be unusual or significant? ☐yes ☐no
If yes, please elaborate here:

What health conditions or issues run in your extended family (parents, grandparents, children, grandchildren, aunts, uncles or cousins)?

Do you have any allergies or bad reactions to prescription or over-the-counter medications?
If yes, please list them along with the symptoms of the allergy or bad reaction.

What chronic medical problems do you have that you didn't mention on the previous page?

Have you had any surgeries? If yes, please list the year and the type of surgery

---

Current Medications and Therapies

Please list any prescription and over-the-counter medications you take, along with the dose and frequency of use.

Please list any health supplements such as vitamins, minerals, herbs, amino acids, or probiotics--along with the dose (if you know it) and frequency of use.

Please list any other doctors and other healers that you've seen in the last year along with their specialty (e.g. dermatology or ophthalmology) or training (e.g chiropractic, acupuncture, massage) and what issues you've been seeing them for.

Preventive Medical Services

Have you had any blood tests done in the past 3 months? ☐yes ☐no
If yes, were the tests done at: ☐LabCorp ☐Quest ☐Scripps ☐Other ☐I don't know

If you're over 50, have you completed an Advance Directive (sometimes called a Living Will)?
Advance Directive? ☐yes ☐no

If you've had any of the following **vaccines**, please check the box and if you know the year, write that in the space on the right:

Flu	☐yes	☐no	If yes, what year or how long ago:
Tetanus (Td or Tdap)	☐yes	☐no	If yes, what year or how long ago:
Pneumovax (original)	☐yes	☐no	If yes, what year or how long ago:
Prevnar-13	☐yes	☐no	If yes, what year or how long ago:
Shingles	☐yes	☐no	If yes, what year or how long ago:

If you're over 50 or have a family history of colon cancer, have you had a colonoscopy? If yes, please write the year as best you recall:
Colonoscopy? ☐yes ☐no If yes, what year or how long ago:

Have you had any gene tests for colon cancer (Cologuard) or any other general gene tests such as 23andme or ancestry.com? ☐yes ☐no

Just for women
If you have had a mammogram, when was your most recent one as best you can recall?
Mammogram? ☐yes ☐no If yes, what year or how long ago:

If you have had a breast exam by a health professional, when was your most recent one as best you can recall? Breast exam? ☐yes ☐no If yes, what year or how long ago:

If you have had a PAP smear, when was the most recent one as best you can recall?
PAP? ☐yes ☐no If yes, what year or how long ago:

If you have had a bone density scan, when was the most recent one as best you can recall?
Bone density scan? ☐yes ☐no If yes, what year or how long ago:

Just for men
If you have had a prostate exam, when was your most recent one as best as you can recall?
Prostate exam? ☐yes ☐no If yes, what year or how long ago:

If you have had a PSA (prostate specific antigen) blood test, when was it as best as you can recall?
PSA? ☐yes ☐no If yes, what year or how long ago:

Lifestyle

Do you follow any special diet, such as low-fat, low carbo, Paleo, pescaterian, vegetarian, vegan, etc?
Special diet? ☐yes ☐no
If yes, please explain here:

What's your typical breakfast?

What's your typical lunch?

What's your typical dinner?

Have you had a bad reaction to any foods such as bloating, flushing, congestion? ☐yes ☐no
If yes, please explain:

In the last few years, have you made any changes in your diet because of your health? ☐yes ☐no
If yes, please explain:

How many alcohol-containing drinks do you have in a typical WEEK?_____

Do you use any tobacco-containing products? ☐yes ☐no

What kind of exercise do you get and how many hours per week do you spend on it?

How many hours of sleep do you usually get?_____

How do you release stress?_____

Review of Systems

Please check the box next to any other concerns that you'd like to discuss with Dr. Bressler.

□ Anti-aging/Longevity	□ Hearing Loss	□ Sadness
□ Low energy	□ Ringing in ears	□ Anxiety
□ Sleep issues	□ Changes in Vision	□ Stress
□ Skin rashes	□ Red eyes	□ Distressing Thoughts
□ Hair loss	□ Dental Issues	□ Relationship Issues
□ Dry Skin	□ Mouth Sores	□ Grief
□ Easy Bruising	□ Voice Changes	□ Anger
□ Swollen Lymph Nodes	□ Urination problems	□ Forgetfulness
□ Frequent Infections	□ Low sex drive	□ Falls
□ Chronic cough	□ Men: erection issues	□ Poor Coordination
□ Shortness of Breath	□ Women: pain w/sex	□ Dizziness
□ Runny or Stuffy Nose	□ Women: other GYN issues	□ Light-headedness
□ Bloody nose	□ Women: menopause issues	□ Headaches
□ Swallowing trouble	□ Thyroid issues	□ Chronic pain
□ Weight change	□ Blood sugar issues	□ Stiff joints
□ Heartburn	□ Palpitations	□ Spiritual Crisis
□ Constipation	□ Chest pain	□ Work Issues
□ Diarrhea	□ Cold extremities	□ STD exposure
□ Bloating	□ Foot or Calf pains	□ Financial issues
□ Abdominal pains	□ Swelling in the feet	□Issues of meaning & purpose
□ Excess Gas	□ Back pain	□Trouble focusing
□ Indigestion	□Muscle spasms	□Tremor/Shaking
□Illness in family member	□ Death in family member	□ Other

DANIEL J. BRESSLER, M.D. F.A.C.P.

PERSONALIZED PRIMARY CARE AND SCIENCE-BASED NATURAL MEDICINE

CLINICAL EXCELLENCE • INTEGRATIVE APPROACH • FRIENDLY ENVIRONMENT

501 WASHINGTON STREET | SUITE 705 | SAN DIEGO, CALIFORNIA 92103

PH: 619.298.0256 | FAX: 619.688.1836 | WWW.DRDANIELBRESSLER.COM | EMAIL: OFFICE@DRDANIELBRESSLER.COM

Consultation Questionnaire

Updated 4/10/14

Name_____ Date of Birth_____ Today's Date_____

What health issues would you like Dr. Bressler to focus on today? Please list them in order of importance to you. Use the other side of the paper or a separate piece of paper if you prefer.

What ongoing/chronic medical problems do you have apart from what you've written about above?

What prescription medicines, non-prescription medicine, vitamins, or herbs do you take regularly?
(Use the other side of the page if necessary)

Name	Dosage	How Often

Do you have any allergies to any medications? If so, what medicine and what was your reaction?

Review of Systems:

Please **circle** any symptoms or problems that you have **currently** or have had recently. Do **not** circle any symptoms or problems that you've already written about on the previous pages.

HEAD: Headaches. Migraines. Head trauma.

EYES: Blurred vision. Glaucoma.

EARS: Hearing loss. Ringing in the ears.

NOSE: Sinusitis. Difficulties with sense of smell.

THROAT: Sore throat. Swallowing difficulty. Lumps. Dry mouth. Painful chewing. Teeth grinding. TMJ dysfunction. Bleeding gums.

PULMONARY: Sleep apnea. Shortness of breath at rest. Unusual shortness of breath with exertion. Cough. Asthma. Wheezing. Coughing up blood. Tuberculosis. Irritating chemical exposure.

CARDIAC: Hypertension. Palpitations. Rapidly heartbeat. Fainting. Arrhythmias. Coronary artery disease/atherosclerosis. Heart attack. Heart murmur.

GASTROINTESTINAL: Acid reflux. Abdominal pain. Nausea. Vomiting. Diarrhea. Constipation. Blackness of stool. Red blood in stool. Hepatitis. Unexpected weight change. Peptic ulcer disease.

GENITOURINARY: Sexual dysfunction. Urinary urgency. Urinary frequency. Urinary hesitancy. Kidney stones. Urinary incontinence.

ENDOCRINE: Elevated cholesterol or triglycerides. Diabetes. Thyroid disease.

MUSCULOSKELETAL: Joint pain. Fibromyalgia. Rheumatoid arthritis. Lupus. Osteoarthritis. Gout.

VASCULAR: Cramps in calf muscles. Non-healing wounds. Blood clots. Pulmonary embolus. Deep venous thrombosis.

NEUROLOGIC: Seizures. Numbness. Tingling. Weakness. Memory impairment. Stroke. Transient ischemic attack.

PSYCHIATRIC: Depression. Stress. Anxiety. Insomnia.

HEMATOLOGIC: Easy bruising. Anemia. Doctor-diagnosed blood disorder.

ONCOLOGIC: Malignancies (cancers).

DERMATOLOGIC: Acne. Brittle nails. Hair loss.

What surgeries have you had and in what year?

_____

_____

_____

_____

_____

_____

Do you use any of the following? (if "yes" indicate the average amount per day)

❑ No ❑ Yes Tobacco (packs) _____ ❑ No ❑Yes Caffeine (cups)_____

❑ No ❑Yes Alcohol (drinks)_____ ❑ No ❑ Yes Other _____

Please list any significant medical conditions among family members:

Mother_____

Father _____

Siblings_____

Children_____

What is your occupation?_____

If retired, what was your occupation, and when did you retire?_____

_____

FOR NURSE AND DOCTOR USE:

Height _____ Weight _____ BP/R _____ BP/L _____ P _____ RR _____

SKIN -☐ +☐ _____

LN -☐ +☐ _____

HEENT -☐ +☐ _____

NECK -☐ +☐ _____

SPINE -☐ +☐ _____

LUNGS -☐ +☐ _____

HEART -☐ +☐ _____

CHEST -☐ +☐ _____

ABD -☐ +☐ _____

EXT -☐ +☐ _____

NEURO -☐ +☐ _____

GU/RECTAL -☐ +☐ _____

CP STUDIES ☐ NO ☐ YES _____

LAB STUDIES ☐ NO ☐ YES _____

RECORD REQUEST ☐ NO ☐ YES

DANIEL J. BRESSLER, M.D. F.A.C.P.

PRIMARY CARE AND NATURAL MEDICINE

CLINICAL EXCELLENCE • PERSONALIZED EXPERIENCE • INTEGRATIVE APPROACH

501 WASHINGTON STREET | SUITE 705 | SAN DIEGO, CALIFORNIA 92103

PH: 619.298.0256 | FAX: 619.688.1836 | WWW.DRDANIELBRESSLER.COM | EMAIL: OFFICE@DRDANIELBRESSLER.COM

PATIENT REGISTRATION

Please Print Clearly.

Today's Date: _____

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell: ( ) _____ Date of Birth: _____

Social Security Number: _____ Sex: ❑ Female ❑ Male

E-mail Address: _____

Best Method of Contact: ❑ Home ❑ Work ❑ Cell ❑ E-mail

May we leave a message for you? If yes, where? ❑ Home ❑ Work ❑ Cell ❑ E-mail

Emergency Contacts

Name _____ Relationship _____

Phone ( ) _____ Email _____

Name _____ Relationship _____

Phone ( ) _____ Email _____

Name _____ Relationship _____

Phone ( ) _____ Email _____

DANIEL J. BRESSLER, M.D. F.A.C.P.

PRIMARY CARE AND NATURAL MEDICINE

CLINICAL EXCELLENCE • PERSONALIZED EXPERIENCE • INTEGRATIVE APPROACH

501 WASHINGTON STREET | SUITE 705 | SAN DIEGO, CALIFORNIA 92103

PH: 619.298.0256 | FAX: 619.688.1836 | WWW.DRDANIELBRESSLER.COM | EMAIL: OFFICE@DRDANIELBRESSLER.COM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed_____ Date_____

Print Name_____ Telephone_____

If not signed by the patient, please indicate:

Relationship: ___ parent or guardian of minor patient
___guardian or conservator of an incompetent patient
___beneficiary or personal representative of deceased patient

Name of Patient_____

Updated 02/18/08