

**NEW PROVIDENCE INTERNAL MEDICINE ASSOCIATES**

**ADOLESCENT PHYSICAL**

Name \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_

Doctor \_\_\_\_\_

Date of Physical \_\_\_\_\_

Please list the following:

1. Significant health problems: \_\_\_\_\_
2. Any previous hospitalization or surgery: \_\_\_\_\_
3. Prescription medications: \_\_\_\_\_
4. Non-prescription medications (vitamins, supplements, herbal, etc): \_\_\_\_\_
5. Allergies to medications: \_\_\_\_\_
6. Do you smoke cigarettes? \_\_\_\_\_
7. Do you get any regular exercise? \_\_\_\_\_
8. How many drinks of alcoholic beverages do you have per week? \_\_\_\_\_
9. Have you used recreational drugs? \_\_\_\_\_
10. Are you sexually active? \_\_\_\_\_
11. Do you wear seatbelts? Bicycle helmet? \_\_\_\_\_

**REVIEW OF SYMPTOMS**

(Please circle any symptom that is recent, frequent, or otherwise significant to you)

***General***

Fatigue; Unintentional weight loss; poor sleep

***Cardiovascular, Heart, Lungs***

Any chest symptom such as pain or pressure (especially with any exertion); Palpitations (abnormal sensation of the heart beating); Shortness of breath; Cough; Wheezing

***Gastrointestinal, Stomach, Intestines***

Heartburn; Nausea; Diarrhea; Constipation; Blood in the stool; Abdominal pain

***Skin***

New rash, spots, or growth; Do you use sunblock? \_\_\_\_\_

***Urinary***

Urination that is painful or frequent; Any discharge from the penis or vagina

***Gynecological*** (women only)

Age began having periods: \_\_\_\_\_; Irregular periods; Date of last Pap test \_\_\_\_\_; Type of birth control used: \_\_\_\_\_

***Neurologic***

Black out or faint; Headaches; Weakness of one side of your body;

***Emotional***

Feelings of being depressed, anxious, sad, or nervous; Any physical or emotional abuse by someone close to you?

Any other medical or health issues that you would like to discuss with the doctor:

\_\_\_\_\_

To be completed by doctor or nurse on the day of the physical:

- Tetanus, Influenza, Hep B, MMR
- Next check-up or visit