HealthONE Skyline Primary Care
Physician Care℠

Return Patient Physical Questionnaire

Patient Name: ______________________________ **Age:** ________ **Date of Birth:** ______________

Section 1: Review of Systems, please check off all the symptoms you have had in the past 4 weeks.

Constitutional:-→	☐ Fever ☐ Chills ☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Weakness ☐ Night Sweats	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Eyes:→	☐ Double vision ☐ Blurred vision ☐ Last Eye Exam:	Other symptoms/problems: ☐ ☐	Notes:
Ears:→	☐ Decreased hearing ☐ Ear pain ☐ Ringing	Other symptoms/problems: ☐ ☐	Notes:
Nose:→	☐ Congestion ☐ Bleeding ☐ Sinus pain ☐ Snoring	Other symptoms/problems: ☐ ☐ ☐	Notes:
Throat/Mouth:→	☐ Pain ☐ Hoarseness ☐ Dental problems ☐ Neck pain	Other symptoms/problems: ☐ ☐ ☐	Notes:
Pulmonary System:→	☐ Cough ☐ Shortness of breath ☐ Stopped breathing during sleep ☐ Dose-off easily during the day	Other symptoms/problems: ☐ ☐ ☐	Notes:
Cardiac System:→	☐ Chest pain ☐ Palpitations ☐ Ankle swelling ☐ Night time urination	Other symptoms/problems: ☐ ☐ ☐	Notes:
Gastrointestinal:→	☐ Indigestion ☐ Heart burn ☐ Abdominal pain ☐ Nausea ☐ Excessive belching ☐ Excessive flatus (gas) ☐ Bloating ☐ Diarrhea ☐ Constipation ☐ Hemorrhoid pain	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Urogenital System:→	☐ Urine Frequency ☐ Urine burning ☐ Urgency ☐ Night time urination ☐ Hesitancy ☐ Dribbling ☐ Incontinence ☐ Weak Stream ☐ Discharge (vaginal or penile) ☐ Sores/ulcers ☐ Vaginal Odor ☐ Abnormal bleeding ☐ Sexual problems ☐ Menstrual problems	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:

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Section 1 continued:

Musculoskeletal:→	☐ Joint pain ☐ Joint swelling ☐ Joint redness ☐ Joint stiffness ☐ Joint grinding ☐ Muscle stiffness ☐ Muscle weakness ☐ Muscle pain ☐ Morning stiffness	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Skin System:→	☐ Rash ☐ Lumps/bumps ☐ Sores ☐ Abnormal moles ☐ Itching	Other symptoms/problems: ☐ ☐ ☐ ☐	Notes:
Neurological:→	☐ Numbness ☐ Weakness ☐ Pain ☐ Headache ☐ Dizziness ☐ Loss of coordination ☐ Loss of balance ☐ Passing out ☐ Tremor	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Psychological:-→	☐ Depression ☐ Loss of interest in things you used to enjoy ☐ Decreased motivation ☐ Decreased energy ☐ Agitation ☐ Insomnia ☐ Sleeping too much ☐ Thoughts of dying ☐ Irritable ☐ Crying spells ☐ Decreased appetite ☐ Increased appetite ☐ Hallucinations ☐ Hearing voices ☐ Worry a lot ☐ Anxious ☐ Obsessive or compulsive ☐ Decreased libido/interest in sex	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Endocrine:→	☐ If you have Diabetes, are you checking your blood sugars? What are they running? ☐ Cold intolerant ☐ Heat intolerant ☐ Hot flashes ☐ Thirsty all the time ☐ Urinate a lot ☐ Hungry all the time	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Hematological:→	☐ Fatigue ☐ Easy bruising ☐ Excessive bleeding	Other symptoms/problems: ☐ ☐	Notes: