931 Oak Park Boulevard, Suite 101
Pismo Beach, CA 93420
(805) 474-2600

ANNUAL CONCIERGE PHYSICAL QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

Physician: _____

All questions contained in this questionnaire are strictly confidential and will become part of your confidential medical records. If you come across any highly sensitive issues that you find difficult to write about but you'd still like to discuss, just indicate that issue with an asterisk (*) and your physician will talk about it during your examination.

CONCIERGE PHYSICAL
DATE: _____
TIME: _____

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REVIEW OF BODY SYSTEMS

If you've experienced any of the below, please indicate (with an X) and describe any symptoms that you are currently experiencing or that are of concern to you.

GENERAL
◻ Fevers ◻ Fatigue ◻ Weakness ◻ Change in Appetite ◻ Change in Weight ◻ Cold or Heat Intolerance ◻ Abnormal Sweating ◻ Flushing ◻ Chronic Pain
HEAD/EYES
◻ Headaches ◻ Dizzy Spells ◻ Faintness ◻ Seizures ◻ Loss of Consciousness ◻ Change in Vision ◻Vision Disturbances
EARS
◻ Straining to Hear ◻ Missing Words ◻ Change in Hearing ◻ Noise in Your Ears ◻ Ear Pain
NOSE
◻ Nasal Congestion ◻ Obstruction ◻ Discharge ◻ Change in Smell
THROAT
◻ Hoarseness ◻ Swollen Glands ◻ Persistent Sore Throat ◻ Neck Pain ◻ Gum or Dental Disease ◻ Floss Regularly ◻ Do Not Floss Regularly ◻ TMJ
BREASTS
◻ Pain ◻ Abnormal Lumps ◻ Skin Changes ◻ Nipple Discharge
RESPIRATORY
◻ Cough ◻ Shortness of Breath ◻ Wheezing ◻ Change in Sputum
CARDIOVASCULAR
◻ Chest Pains ◻ Palpitations ◻ Irregular Heart Beats ◻ Swollen Feet or Ankles ◻ Varicose Veins ◻ Calf or Leg Pains with Walking ◻ Hypertension (Year of onset: _____)
GASTROESOPHAGEAL
◻ Nausea ◻ Vomiting ◻ Difficulty Swallowing ◻ Indigestion ◻ "Heartburn" ◻ Abdominal Pain ◻ Bloating ◻ Burping ◻ Gas ◻ Symptoms of Reflux
INTESTINAL
◻ Lower Abdominal Pain ◻ Constipation ◻ Diarrhea ◻ Excessive Flatus ◻ Hemorrhoids ◻ Rectal Pain ◻ Rectal Bleeding ◻ Change in Shape, Color, Frequency, Consistency of Bowel Movements
URINARY SYSTEM
◻ Increased Urinary Frequency ◻ Change in Urinary Stream ◻ Intermittent Stream ◻ Pain or Burning with Urination ◻ Getting up at Night to Urinate (No. of times: _____) ◻ Loss of Urine with Coughing, Sneezing or Effort ◻ History of Herpes or STDs: _____
MUSCULOSKELETAL
◻ Arthritis-Joint Pains ◻ Neck or Back Pain ◻ Muscle Pain or Weakness ◻ Tendonitis ◻ Bursitis ◻ Gout ◻ Foot Problems ◻ Change in Posture ◻ Disc Disease Disorder of Nerves or Muscles
SKIN, HAIR, NAILS
◻ Rashes ◻ Itching ◻ Psoriasis ◻ Seborrhea ◻ Acne ◻ Dry or Oily Skin ◻ Changes in Quality of Hair ◻ Excessive Hair Growth or Hair Loss ◻ Skin Cancers ◻ Persistent Sores ◻ Abnormal Pigmentation ◻ Changes in Nails
NEUROLOGICAL
◻ Changes in Memory ◻ Thinking ◻ Concentration or Speech ◻ Tremors ◻ Difficulties with Movement of Extremities ◻ Change in Balance or Gait ◻ Disorders of Sensation
HEMATOLOGIC
◻ Anemia ◻ Bruising ◻ Swollen Glands

FOR WOMEN
Age when Menses Began _____ Age of Menopause _____
◻ Painful Menstruation ◻ Heavier or Lighter Periods ◻ Irregular Periods ◻ Vaginal Discharge
◻ Vaginal Dryness or Irritation
Methods of Birth Control: _____
of Pregnancies (Total) _____ # of Miscarriages _____ # of Abortions _____
◻ Presently Pregnant or Breastfeeding ◻ Possibly Pregnant ◻ Change in Libido (Sexual Interest)
◻ Any issues about sexual fulfillment or sexual activity with regard to self or partner?
If yes, please explain:
Have you taken or do you take hormone replacement therapy? ◻ Yes ◻ No
◻ Early loss of ovarian function ◻ Hyperthyroidism ◻ Chronic diarrhea or intestinal malabsorption syndrome
◻ Have you had an eating disorder such as anorexia or bulimia? ◻ Low calcium intake ◻ Little or no exposure to sun
◻ High caffeine intake (2-3 cups/day) ◻ Perform physical activity excessively (causing missed periods)
◻ History of inflammatory bowel disease ◻ Obesity ◻ History of colorectal cancer or polyps
◻ Heavy alcohol use ◻ Inactive lifestyle

FOR MEN
◻ Changes in Urinary Stream ◻ Changes in Libido (Sexual Interest)
Methods of Birth Control: _____
Any issues concerning… (check all that apply)
◻ Premature Ejaculation
◻ Erectile Dysfunction
◻ Sexual Activity or Fulfillment with Regard to Self or Partner
◻ If yes, explain: _____
◻ Hyperthyroidism ◻ Chronic diarrhea or intestinal malabsorption syndrome
◻ Have you had an eating disorder such as anorexia or bulimia? ◻ Low calcium intake ◻ Little or no exposure to sun
◻ High caffeine intake (2-3 cups/day)
◻ History of inflammatory bowel disease ◻ Obesity ◻ History of colorectal cancer or polyps
◻ Heavy alcohol use ◻ Inactive lifestyle

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NUTRITION SURVEY

Please check off and elaborate as necessary.

How would you rate your diet in general?

□ Very Healthy □ Healthy □ Moderately Healthy □ Unhealthy □ Very Unhealthy

Comments:

_____

_____

Please describe the healthy aspects and unhealthy aspects of your diet:

_____

_____

Which improvements would you like to achieve:

☐ Lower Salt	☐ Less Candy/Chocolate
☐ Lower Far, Cholesterol	☐ Fewer Cakes/Pies Cookies
☐ Less Oil, Mayo, Butter	☐ Less Bread, Potatoes, Rice, Pasta
☐ More Calcium	☐ Less Fried Food
☐ More Calories, Fewer Calories	☐ Less Snack Food
☐ More Whole Grains, More Fiber	□ Less "Junk" Food – Describe
□ More Fruits and Vegetables	□ Fewer Carbohydrates
□ More Carbohydrates	□ Less Protein
□ More Protein	□ Less Meat, More Fish, More Soy
□ Less Fast Food	□ Smaller Portion Size
□ Less Alcohol	□ Fewer Pesticides

On average what is the total number of servings of fruits and vegetables that you have each day? _____

Which fruits and vegetables do you like? _____

Which fruits and vegetables do you not like? _____

Do any of these apply to you? (check all that apply)

□ Milk Intolerance □ Hypoglycemia □ Food Allergies or Other Food Intolerance

Would you like more information about nutrition? □ Yes □ No

What kind, how can we help you? (please explain)

_____

_____

EXERCISE HABITS

Please reply to questions and elaborate as needed.

How would you rate your present exercise habits?

□ Excellent □ Good □ Moderate □ Poor □ Very Poor

Please describe your present exercise habits (type and frequency):

List some of the benefits of exercise:

What have your exercise habits been like in the past?

Do you enjoy exercise? (please comment)

What are some of your goals regarding exercise?

What has allowed you to reach your goals? What keeps you from reaching your goals?

Types of exercise you perform (please circle and comment below):

Swim Walk Jog Run Treadmill Roller Blade

Bicycle Basketball Baseball Sailing Dance Golf

Tennis Tai Chi Judo Weight Lifting Handball Gardening

Gym Machines Aerobics Class House Cleaning Demanding Physical Labor at Work

Other(s):

_____

Comments:

_____

_____

THE EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

SITUATION	CHANCE OF DOZING (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g., a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 & up	Very sleepy and should seek medical advice

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at All	Several Days	More than Half of the Days	Nearly Every Day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating		1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
				PHQ-9 Total Score:	
10	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at work, take care of things at home, or get along with other people?	Not difficult at all _____	Somewhat difficult _____	Very difficult _____	Extremely difficult _____

Q6 CORE 10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at All	Several Days	More than Half of the Days	Nearly Every Day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
				GAD-7 Total Score:	