PHYSICAL EXAM FORM

PBPM | 701 Northpoint Parkway | Suite 140 | West Palm Beach, FL 33407

Name: _____
FIRST MIDDLE LAST

SSN: _____ **DOB:** _____

Height: _____ ft. _____ in. **Weight:** _____ **BMI:** _____

Blood Pressure: _____ **Pulse:** _____ **Respiration:** _____ **0_2 Sat:** _____ %

Allergies: _____

Medications: _____

Surgical History: _____

Significant Family Medical History: _____

Social History:

Do you smoke?	□ Yes	□ No	Do you exercise regularly?	□ Yes	□ No
Do you drink alcohol?	□ Yes	□ No	Do you follow a specific diet?	□ Yes	□ No
OTC supplements?	□ Yes	□ No			

Physical Exam On examination, is there any abnormality of the following:

YES	NO	*(If YES, please explain in the CC/Notes below)*
□	□	Head, eyes, ears, nose, mouth, pharynx?
□	□	Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?
□	□	Nervous system (include reflexes, gait, paralysis)?
□	□	Heart rate?
□	□	Heart rhythm?
□	□	Presence of heart murmur?
□	□	Lungs?
□	□	Genitourinary system (by history)?
□	□	Endocrine system (include thyroid and breasts)?
□	□	Musculoskeletal system (include spin, joints, amputations, deformities)?
□	□	Are there any hernias (by history)?
□	□	Are you aware of (or suspect) any other medical, alcoholic, or drug history?

Name: _____ **DOB:** _____

HRT History:

Hx of HRT? □ Yes □ No Any adverse/unwanted effects of HRT? □ Yes □ No

Date of last testosterone injection: _____ Current dose of testosterone: _____

Sleep difficulties? □ Yes □ No Pain issues? □ Yes □ No Urination at night (nocturia)? □ Yes □ No

Personal or family hx of prostate cancer? □ Yes □ No Personal or family hx of blood clots? □ Yes □ No

FOR WOMEN ONLY: Symptoms/Past Diagnosis *(Please check all that apply)*

□ Fibromyalgia	□ Uterine Fibroids	□ Dry Skin or Dry Hair
□ Migraines	□ Hot Flashes	□ Mood Swings
□ Ovarian Cysts	□ Night Sweats	□ Breast Tenderness
□ Osteoporosis/Osteopenia	□ Vaginal Dryness	□ Water Retention

Date of last menstruation period:_____

Date of last Mammogram:_____ Any abnormalities? □ Yes □ No

▸ If so, please provide date and details about any abnormal mammograms you've had:

Date of last menstruation Pap Smear:_____ Any abnormalities? □ Yes □ No

▸ If so, please provide date/details of any abnormal Pap Smear tests you've had:

Please rate the following on a scale of 1-10 (10 being the highest):

MOOD: [ ] ENERGY: [ ] LIBIDO: [ ] STRESS: [ ]

CC/Notes:

Recommendations:

_____ _____
Print medical examiner's name Date of exam

_____
Medical examiner's signature