

PETRA TRAVNICEK, MD, FACP



CONCIERGE BIENNIAL EXAMINATION

PATIENT NAME: _____

DATE: _____ DOB: ____/____/____

PLEASE LIST ANY MAJOR SYMPTOMS YOU ARE HAVING WITH YOUR HEALTH, NEW MEDICAL PROBLEMS YOU HAVE BEEN DIAGNOSED WITH IN THE PAST 6 MONTHS, OR ANY NEW CONCERNS YOU HAVE:

HAVE YOU HAD SURGERIES IN THE PAST 6 MONTHS? _____ YES _____ NO

IF YES, PLEASE COMPLETE:

| SURGERY | DATE OF SURGERY | SURGEON'S NAME |
|---------|-----------------|----------------|
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REVIEW OF BODY SYSTEMS

CHECK ANY SYMPTOMS YOU ARE EXPERIENCING OR THAT ARE CONCERNING YOU:

CONSTITUTIONAL: ___FEVER ___FATIGUE ___ABNORMAL SWEATING ___WEAKNESS ___CHANGE IN WEIGHT
___CHANGE IN APPETITE ___DIFFICULTY SLEEPING ___INTOLERANCE TO HEAT OR COLD

HEAD: ___HEADACHE ___DIZZY ___FAINT ___SEIZURES

EYES: ___LOSS OF VISION ___FLOATERS ___EYE PAIN

EARS: ___NOISE IN EARS ___HEARING LOSS ___EAR PAIN

NOSE: ___CONGESTION ___CHANGE IN SMELL ___LOSS OF SMELL

BREASTS: ___PAIN ___LUMPS ___NIPPLE CHANGES OR DISCHARGE

RESPIRATORY: ___COUGH ___SHORTNESS OF BREATH ___WHEEZING ___CHANGE IN SPUTUM

CARDIOVASCULAR: ___CHEST PAIN ___PALPITATIONS ___IRREGULAR HEARTBEATS ___VARICOSE VEINS
___PAIN IN CALF WITH WALKING

GASTROINTESTINAL: ___NAUSEA ___VOMITING ___DIFFICULTY SWALLOWING ___INDIGESTION
___ABDOMINAL PAIN ___BURPING ___BLOATING

INTESTINAL: ___PAIN ___CONSTIPATION ___DIARRHEA ___EXCESSIVE FLATULENCE
___HEMORRHOIDS ___RECTAL PAIN ___RECTAL BLEEDING ___CHANGE IN STOOL

URINARY: ___INCREASED FREQUENCY ___CHANGE IN STREAM ___PAIN WITH URINATION
___URGENCY ___INCONTINENCE ___LOSS OF URINE WHEN COUGHING OR SNEEZING
___GETTING UP AT NIGHT TO URINATE (HOW MANY TIMES? ___)

WOMEN: ___PAINFUL MENSTRUATION ___CHANGE IN PERIODS ___PAINFUL INTERCOURSE
___VAGINAL DISCHARGE ___VAGINAL DRYNESS OR IRRITATION ___CHANGES IN LIBIDO

MEN: ___CHANGES IN LIBIDO ___PREMATURE EJACULATION ___ERECTILE DYSFUNCTION

MUSCULOSKELATOL: ___PAINFUL JOINTS ___SWOLLEN JOINTS ___ARTHRITIC CHANGES
LIST JOINTS _____
___TENDONS ___GOUT ___FOOT PROBLEMS ___MUSCLE PAIN OR WEAKNESS

SKIN: ___RASHES ___ITCHING ___ACNE ___PERSISTENT SORES ___SKIN CANCERS
___HAIR LOSS ___SEBORRHEA ___PSORIASIS

HEMATOLOGY: ___BRUISING ___SWOLLEN GLANDS

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EXERCISE HABITS

PLEASE DESCRIBE YOUR EXERCISE

TYPE: _____

FREQUENCY: _____

OTHER TYPES OF PHYSICAL ACTIVITY:

GOALS FOR EXERCISE THIS YEAR:

HOW WILL YOU ACHIEVE THESE GOALS:

COMPLETED BY _____ DATE _____

SIGNATURE _____

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AFTER COMPLETED SIGN AND EMAIL TO FORMS@CONCIERGE MEDICAL.SERVICES
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