

NACHAAT MOURAD, MD



CONCIERGE ANNUAL 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 YEAR, OR ANY NEW CONCERNS YOU HAVE:

HAVE YOU HAD SURGERIES IN THE PAST YEAR? _____ **YES** _____ **NO**

IF YES, PLEASE COMPLETE:

SURGERY	SURGERY DATE	SURGEONS NAME	ADDRESS	PHONE

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CURRENT MEDICATIONS / VITAMINS / SUPPLEMENTS / HERBS

NAME OF MEDICATION	STRENGTH	TIME OF DAY TAKEN

PLEASE LIST ANY NEW ALLERGIES AND THE REACTIONS:

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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

MUSCULOSKELETAL: ☐ 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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CONSUMPTION

TOBACCO:

DO YOU SMOKE? ____ YES ____ NO DID YOU QUIT OR CUT BACK ON SMOKING? ____ YES ____ NO

ALCOHOL - OUNCES PER: DAY _____ WEEK _____ MONTH _____ (BEER/WINE/LIQUOR)

CAFFEINE: # _____ CUPS OF CAFFEINATED BEVERAGES PER DAY (COFFEE, TEA & SODA)

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 _____

CAREFULLY REVIEW ALL PAGES TO BE SURE YOU HAVE FILLED OUT EACH PAGE COMPLETELY.
AFTER COMPLETED, SIGN AND EMAIL TO FORMS@CONCIERGEMEDICAL.SERVICES
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