**Petra Travnicek, MD, FACP**

CONCIERGEMEDICAL SERVICES

BOARD CERTIFIED INTERNAL MEDICINE

# 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

1250 South Tamiami Trail, Suite 301, Sarasota, FL 34239
Ofc (941) 365-1321 Fax (941) 365-4071 www.conciergemedical.services

**Petra Travnicek, MD, FACP**

CONCIERGEMEDICAL
SERVICES

BOARD CERTIFIED INTERNAL MEDICINE

## Current Medications / Vitamins / Supplements / Herbs

| Name of Medication | Strength | Time of Day Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Please list any NEW allergies and the reactions:

1250 South Tamiami Trail, Suite 301, Sarasota, Fl 34239
Ofc (941) 365-1321 Fax (941) 365-4071 www.conciergemedical.services

**Petra Travnicek, MD, FACP**

CONCIERGEMEDICAL SERVICES

BOARD CERTIFIED INTERNAL MEDICINE

## Review of Body Systems

### Check any symptoms you are experiencing or that are concerning you:

**Constitutional:** ___Fever ___Fatique ___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
Listjoints_____
___Tendons ___Gout ___Foot problems ___Muscle pain or weakness

**Skin:** ___Rashes ___Itching ___Acne ___Persistent sores ___Skin cancers
___Hair loss ___Seborrhea ___Psoriasis

**Hematology:** ___Bruising ___Swollen glands

1250 South Tamiami Trail, Suite 301, Sarasota, FL 34239
Ofc (941) 365-1321 Fax (941) 365-4071 www.conciergemedical.services

**Petra Travnicek, MD, FACP**

CONCIERGEMEDICAL
SERVICES
BOARD CERTIFIED INTERNAL MEDICINE

## 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 caffeineted 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 or print, sign and mail to: 1250 S Tamiami Trail, Suite 301, Sarasota, FL 34239.**