Family Clinic of Fort Collins
EST 1971
A PROFESSIONAL LIMITED LIABILITY PARTNERSHIP

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CERTIFIED AMERICAN ACADEMY OF NURSE PRACTIONERS

Complete Physical Examination or Gyn (Pap) Examination

Name _____ SS # _____ Date _____
Address _____ Occupation _____
Phone H_____ Wk _____ Other _____ Date of Birth _____ Age _____
☐M ☐F Email _____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Kids
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Bleeding/Clotting disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

For Women:
Last menstrual period _____ Birth control _____
Periods: ☐ Reg ☐ Irreg ☐ Pain/Cramps ☐PMS
Number of: Pregnancies ___ Abortions ___ Miscarriages ____ Births ___
Frequency of Self Breast Exams: ☐ Occasional ☐ monthly ☐ never
Year of last:
Pap yr: ___ ☐ Nl ☐ Abnl MMG ___ ☐ Nl ☐ Abnl
Menopausal Symptoms: ☐ Hot flashes ☐Night Sweats ☐ Mood Swings
☐Vaginal Drvness ☐Decreased Libido

Current Concerns or Problems:

_____
_____
_____
_____

Dr. Sig _____ Date: _____