Affiliated Physician MDVIP

Viraj V. Tirmal, MD
Internal Medicine

*Viraj V. Tirmal, MD LLC*

Name:_____

Date of Birth:_____Today's Date:_____

# MDVIP Annual Wellness Exam

## REVIEW OF SYSTEMS

**Please check if any of the following applied to you in the last year. If you completed this form last year or more recently, please provide updates:**

**Constitutional**

- fever ☐
- night sweats ☐
- weight gain (lbs) _____ ☐
- weight loss (lbs) _____ ☐
- exercise intolerance ☐
- lethargy ☐
- insomnia ☐
- snoring ☐
- fatigue ☐

**Eyes**

last eye exam: _____

- dry eyes ☐
- irritation ☐
- cataracts ☐
- vision change ☐
- glaucoma ☐
- wears contacts ☐
- wears glasses ☐

**Ears**

- difficulty hearing ☐
- ear pain ☐
- tinnitus (ringing in ears) ☐
- wears hearing aids ☐

**Nose**

- frequent nose bleeds ☐
- nose problems ☐
- sinus problems ☐
- nasal congestion ☐

**Mouth/Throat**

- up to date with dental cleanings ☐
- flosses ☐
- sore throat ☐
- bleeding gums ☐
- dry mouth ☐
- oral abnormalities ☐
- mouth ulcer ☐
- poor dentition ☐
- mouth breathing ☐
- thrush ☐
- cold sores ☐

**Allergy/Immunologic**

- runny nose ☐
- sinus pressure ☐
- itching ☐
- hives ☐
- frequent sneezing ☐

**Cardiovascular**

- chest pain on exertion ☐
- arm pain on exertion ☐
- shortness of breath when walking ☐
- orthopnea (shortness of breath with lying down) ☐
- palpitations ☐
- known heart murmur ☐
- light-headed on standing ☐
- paroxysmal nocturnal dyspnea (waking up in the middle of the night with severe shortness of breath and needing to sit on the side of the bed to catch your breath) ☐
- abnormal blood pressure ☐
- leg claudication (pain in calf after walking a certain distance) ☐

**Respiratory**

- cough ☐
- wheezing ☐
- shortness of breath ☐
- coughing up blood ☐
- sleep apnea ☐
- productive cough ☐

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**Gastrointestinal**

- abdominal pain ☐
- vomiting ☐
- change in appetite ☐
- black or tarry stools ☐
- frequent diarrhea ☐
- vomiting blood ☐
- dyspepsia (indigestion) ☐
- esophageal reflux ☐
- constipation ☐
- difficulty swallowing ☐
- bright red blood per rectum ☐
- rectal bleeding ☐
- hemorrhoids ☐
- anorexia ☐
- bloating ☐
- early satiety ☐

**Genitourinary**

- urinary loss of control ☐
- difficulty urinating ☐
- increased urinary frequency ☐
- hematuria ☐
- difficulty emptying bladder ☐
- urgency ☐
- nocturia (waking up to pee in the middle of the night) # of times _____ ☐
- dysuria ☐
- dribbling ☐
- STDs ☐

**Musculoskeletal**

- muscle aches ☐
- muscle weakness ☐
- arthralgias/joint pain ☐
- back pain ☐
- swelling in the extremities ☐
- Raynaud's Phenomena (reduced blood flow to the fingers/toes with exposure to cold) ☐
- neck pain ☐

**Integumentary / Skin**

- abnormal mole ☐
- jaundice ☐
- rash ☐
- itching ☐
- dry skin ☐
- growths/lesions ☐
- laceration ☐
- nail problems ☐
- nail fungus ☐
- acne ☐
- rosacea ☐
- warts ☐
- urticaria (hives) ☐

**Neurologic**

- syncope ☐
- weakness ☐
- numbness ☐
- seizures ☐
- dizziness ☐
- frequent or severe headaches ☐
- migraines ☐
- restless legs ☐
- tremor ☐
- memory concerns out of the ordinary ☐

**Psychiatric**

| | |
|---|---|
| depression | ☐ |
| sleep disturbances | ☐ |
| feeling unsafe in relationship | ☐ |
| restless sleep | ☐ |
| alcohol abuse | ☐ |
| anxiety | ☐ |
| hallucinations | ☐ |
| suicidal thoughts | ☐ |

**Endocrine**

| | |
|---|---|
| increased thirst | ☐ |
| hair loss | ☐ |
| increased hair growth | ☐ |
| cold intolerance | ☐ |

**Hematologic/Lymphatic**

| | |
|---|---|
| history of transfusions | ☐ |
| swollen glands | ☐ |
| easy bruising | ☐ |
| excessive bleeding | ☐ |

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# FAMILY HISTORY

**Please answer the following. If you completed this form last year, please provide updates, if applicable.**

Please list your parent's medical conditions, age of onset of those conditions (if known), and if deceased, age of death:

Father:

Mother:

Please list your sibling's names with their gender, how many years older/younger they are, their medical conditions, age of onset of those conditions (if known), and if deceased, age of death:

Please list your children's names with their gender, birth date/year, their medical conditions, age of onset of those conditions (if known), and if deceased, age of death:

# SURGICAL HISTORY

Please list any/all procedures you have underwent, date of the procedure (or approximate date), and who performed the procedure (if known):

# PROVIDER LIST

Please list all your other care providers with their area of expertise (specialists, dentist, optometrist, etc.):

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# SOCIAL HISTORY

**Please answer the following. If you completed this form last year, please provide updates, if applicable.**

**Substance Use:**

*Tobacco use:*

Have you ever smoked tobacco? Never ☐ Former ☐ Current ☐

How many years have you smoked tobacco?_____

At what age did you start smoking tobacco?_____

How much tobacco do/did you smoke?_____

When did you quit smoking?_____

Have you ever used any other forms of tobacco or nicotine? Yes ☐ No ☐

Have you ever used e-cigarettes or vape? Never ☐ Former ☐ Current ☐

Have you ever used smokeless tobacco? Never ☐ Former ☐ Current ☐

Date of most recent tobacco screening?_____

*Alcohol use:*

Level of alcohol consumption: None ☐ Occasional ☐ Moderate ☐ Heavy ☐

How many times per week do you consume alcohol?_____

How many alcoholic drinks do you consume per day on average?_____

How many days in the past year have you consumed 4 or more drinks?_____

Have you ever been counseled for unhealthy alcohol use?_____

*Illicit or Recreational Drugs:*

Do you use any illicit or recreational drugs? Yes ☐ No ☐

Which illicit or recreational drugs have you used?_____

*Caffeine:*

What is your level of caffeine consumption?

None ☐

1 cup per day ☐

2 cups per day ☐

3 cups per day ☐

**Diet and Exercise:**

What type of diet are you following?

- Regular ☐
- Vegetarian ☐
- Vegan ☐
- Gluten Free ☐
- Carbohydrate ☐
- Cardiac ☐
- Diabetic ☐
- Specific ☐_____

Do you engage in light exercise (e.g. light walking, housework, etc)? Yes ☐ No ☐

How often are you engaging in light exercise?

- None ☐
- Less than monthly ☐
- 1-3 times per month ☐
- 1-3 times per week ☐
- 4-6 times per week ☐
- Daily ☐
- Other ☐_____

Do you engage in moderate/heavy exercise (e.g. brisk walk, jogging, strength training, etc)?

Yes ☐ No ☐

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?_____

On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise?_____

**Marriage and Sexuality:**

What is your relationship status?

- Married ☐
- Single ☐
- Divorced ☐
- Separated ☐
- Widowed ☐
- Domestic partner ☐
- Other ☐

Are you sexually active? Yes ☐ No ☐

How many children do you have?_____

**Education and Occupation:**

What is the highest grade or level of school you have completed or the highest degree you have received?

- Never attended/kindergarten only ☐
- 1st grade ☐
- 2nd grade ☐
- 3rd grade ☐
- 4th grade ☐
- 5th grade ☐
- 6th grade ☐
- 7th grade ☐
- 8th grade ☐
- 9th grade ☐
- 10th grade ☐
- 11th grade ☐
- 12th grade, no diploma ☐
- GED or equivalent ☐
- High school graduate ☐
- Some college, no degree ☐
- Associate degree: occupational, technical, or vocational program ☐
- Associate degree: academic program ☐
- Bachelor's degree (e.g. BA, AB, BS) ☐
- Master's degree (e.g. MA, MS, MEng, Med, MSW, MBA) ☐
- Professional school degree (e.g. MD, DDS, DVM, JD) ☐
- Doctoral degree (e.g. PhD, EdD) ☐
- Don't know ☐
- Refused ☐

Are you currently employed? Yes ☐ No ☐

What is/was your occupation?_____

**Lifestyle**

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?

- Not at all ☐
- Only a little ☐
- To some extent ☐
- Rather much ☐
- Very much ☐

Do you use your seat belt routinely? Yes ☐ No ☐

**Home and Environment Safety**

Do you have smoke and carbon monoxide detectors in your home? Yes ☐ No ☐
Are you passively exposed to smoke? Yes ☐ No ☐
Are there any guns present in your home? Yes ☐ No ☐
Do you use sunscreen routinely? Yes ☐ No ☐

**Public Health and Travel**

Have you recently traveled abroad? Yes ☐ No ☐
Where to?_____

**Activities of Daily Living**

Are you able to care for yourself? Yes ☐ No ☐
Are you blind or do you have difficulty seeing? Yes ☐ No ☐
Are you deaf or do you have serious difficulty hearing? Yes ☐ No ☐
Do you have difficulty concentrating, remembering or making decisions? Yes ☐ No ☐
Do you have difficulty walking or climbing stairs? Yes ☐ No ☐
Do you have difficulty dressing or bathing? Yes ☐ No ☐
Do you have difficulty doing errands alone? Yes ☐ No ☐
Do you have transportation difficulties? Yes ☐ No ☐
Which of your hands is dominant?

Right ☐
Left ☐
Bilateral ☐

**Advance Directive**

Do you have an advance directive? Yes ☐ No ☐
If you were to collapse and your heart was stopped, do you want me to try to revive you and send you to the hospital? Yes (Full Code) ☐ No (Do not resuscitate) ☐
Do you have an out of hospital DNR? Yes ☐ No ☐
Do you have a medical power of attorney? Yes ☐ No ☐
Is blood transfusion acceptable in an emergency? Yes ☐ No ☐



Submit