**CAPE REGIONAL PHYSICIANS ASSOCIATES**

**Patient Annual / Sick Visit Exam Form**

Have you been to an emergency room or admitted to the Hospital since your last visit?  
No / Yes

If Yes, please explain: _____________________________________________________________________________  
_____________________________________________________________________________________________

Do you need any medication refill(s)?
_____________________________________________________________________________________________
_____________________________________________________________________________________________

If your pharmacy information has changed since your last visit, please provide the following  
(include Pharmacy Name, Street and City):

Local pharmacy: ________________________________________________________________________________

Mail order pharmacy: ____________________________________________________________________________

**Preferred Notification Method:**  
Postal Mail  Phone  Email

**Reason(s) for visit TODAY:** ____________________________________________________________________________

**Review of Systems:**

Please circle any symptoms you are CURRENTLY experiencing that relate to the reason for TODAY’s visit:

<table>
<thead>
<tr>
<th>General</th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in appetite</td>
<td>Fatigue</td>
<td>Fever</td>
<td>Night Sweats</td>
<td></td>
</tr>
<tr>
<td>Weight change</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Change in wart mole</td>
<td>Hives</td>
<td>Itching, persistent</td>
<td></td>
</tr>
<tr>
<td>New lesions</td>
<td>Rash</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Head, Eye, Ear, Nose, Throat</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>Decreased Night Vision</td>
<td>Dry Eyes</td>
<td>Itchy/Watery Eyes</td>
<td></td>
</tr>
<tr>
<td>Visual disturbances</td>
<td>Decreased hearing</td>
<td>Ear discharge</td>
<td>Ear pain</td>
<td></td>
</tr>
<tr>
<td>Ringing of the ears</td>
<td>Vertigo</td>
<td>Runny nose</td>
<td>Nose bleeds</td>
<td></td>
</tr>
<tr>
<td>Frequent colds</td>
<td>Nasal congestion</td>
<td>Seasonal allergies</td>
<td>Sinus pain</td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td>Voice changes</td>
<td>Difficulty swallowing</td>
<td>Dizziness</td>
<td></td>
</tr>
<tr>
<td>Wearing glasses or contact lenses</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Neck</th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck mass</td>
<td>Neck pain</td>
<td>Swollen glands</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory</th>
<th></th>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Cough</td>
<td>Bloody sputum</td>
<td>Difficult breathing</td>
<td>Difficulty lying flat</td>
<td></td>
</tr>
<tr>
<td>Snoring</td>
<td>Sputum production</td>
<td>Wheezing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Patient Name __________________________ Date Of Birth __________________________**

**CRPA Annual / Sick Visit**

### Breast
- Breast mass/lumps
- Breast pain or changes

### Cardiovascular
- **Breast**
  - Breast mass/lumps
  - Breast pain or changes
- **Cardiovascular**
  - Chest pain
  - Rapid heart beat
  - Difficulty breathing on exertion
  - Chest pressure
  - Extra heart beats
  - Wake up short breath
  - Palpitations
  - Hypertension
  - Swelling in legs/ankles
  - Irregular heart beat
  - Low blood pressure

### Gastrointestinal
- Nausea
- Change in bowel habits
- Blood in stool
- Vomiting
- Abdominal pain
- Constipation
- Bloating
- Diarrhea
- Heartburn

### Female Genitourinary
- Burning urination
- Vaginal itching
- Difficulty controlling urination
- Urgency
- Menstrual irregularities
- Painful intercourse
- Bleeding between periods
- Vaginal discharge
- Menstrual pain

### Male Genitourinary
- Frequency
- Difficulty controlling urination
- Burning on urination
- Blood in urine
- Urgency
- Painful urination

### Musculoskeletal
- Joint pain, location
- Muscle aches
- Myalgia
- Fractures

### Neurological
- Tingling
- Numbness
- Weakness
- Dizziness
- Fainting
- Headaches
- Seizures
- Loss of consciousness

### Psychiatric
- Anxiety
- Trouble falling asleep
- Feeling little interest in things
- Depression
- Trouble staying asleep
- Thoughts of suicide
- Change in sleep pattern
- Feeling hopeless

### Endocrine
- Temperature intolerance
- Skin changes
- Excessive thirst
- Excessive urination
- Hair changes

### Hematology
- Abnormal bleeding
- Prolonged bleeding
- Easy bruising
- Anemia
- Enlarged lymph nodes
- Nose bleeds

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**Signature of patient or guardian**

**Printed name of patient or guardian**

**Date**

CRPA Annual / Sick Visit