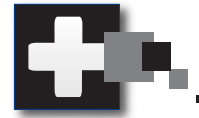


BART PRICE, MD



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PATIENT NAME: _____

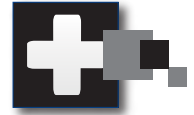
DATE: _____ DOB: ____/____/____

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	DATE OF SURGERY	SURGEON'S NAME



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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? ___)

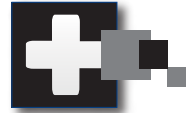
WOMEN: ___ PAINFUL MENSTRUATION ___ CHANGE IN PERIODS ___ PAINFUL INTERCOURSE
___ VAGINAL DISCHARGE ___ VAGINAL DRYNESS OR IRRITATION ___ CHANGES IN LIBIDO

MEN: ___ CHANGES IN LIBIDO ___ PREMATURE EJACULATION ___ ERECTILE DYSFUNCTION

MUSCULOSKELATOL: ___ 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 _____

(PRINT THEN SIGN DOCUMENT)

**CAREFULLY REVIEW ALL PAGES TO BE SURE YOU HAVE FILLED OUT EACH PAGE COMPLETELY.
AFTER COMPLETED, PRINT, SIGN, SCAN AND EMAIL TO JMARINELLI@MANASOTAMED.COM
OR PRINT, SIGN AND MAIL TO: 1250 SOUTH TAMIAMI TRAIL, SARASOTA, FL 34239.**