Bart Price, MD

CONCIERGEmedical SERVICES

Price & Travnicek

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	Date of Surgery	Surgeon's Name

1250 South Tamiami Trail, Suite 30, Sarasota, FL 34239
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Current Medications / Vitamins / Supplements / Herbs

Name of Medication	Strength	Frequency

Please list any NEW allergies and the reactions:

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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

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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 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 _____

(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.

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