

Patient name: _____

DOB: _____

Important Information on Physicals & Well Child Checks

Please read the following information before your scheduled physical.

1. A Physical is a “Wellness Visit”:

- The purpose of this visit is to discuss disease prevention and healthy lifestyle choices, as well as ordering screening lab tests or immunizations.
- **Your insurance may or may not pay for this visit**
- A Physical *does not* cover discussion or treatment of existing or new medical problems, with a distinct diagnosis, or cover medication refills used to treat your medical problems.
- Medicare requires us to perform the PHQ9 depression screening test and will pay for this test. However other insurance companies may not cover this. Let your doctor know if you are declining this test, prior to the start of your exam.
- Lab services, such as bloodwork, urinalysis, pap smears, etc., are billed through outside companies. These laboratories will bill you separately for these services. It is your responsibility to know whether or not these labs are in network with your insurance company.
- Your provider may request a return visit to discuss abnormal findings on your tests or lab results. ***This visit will not be covered under your Physical, and will be charged as a “Problem-oriented Visit”.***

2. Discussion and treatment of medical problems is a “Problem-Oriented Visit”:

- While your doctor may be willing to discuss any and all of your medical issues at the time of your Physical, time allowing, be aware that these are not covered in your “Wellness Visit”

3. Billing for “Physicals” and “Problem-oriented Visits”:

- Your insurance may be charged for both a “Physical” and a “Problem-oriented Visit”.
- Your insurance company may require a co-pay for both visits
- If your insurance plan has a deductible, then your insurance will likely apply the “Problem-oriented Visit” toward your deductible.

4. Your insurance will be charged according to the type of visit(s):

- Your provider will code and bill your visit according to the documentation in your medical record. You will be responsible for payment if your insurance company refuses to pay for the visit.
- The clinic and your provider will not change the type of service billed if your insurance company denies payment. To do so may be in violation of the contract with your insurance company and/or may be construed as insurance fraud.

By signing this, I acknowledge that I have read & understood the above information and agree to pay any additional costs:

Signature of patient (or Guardian if under 18)

Printed name

Date

Today's Date: _____



Name: _____ Date of Birth: _____

Please list any medications, vitamins, supplements, or over the counter products you take. Attach additional pages if needed.

Medication Name	Dose/Amount	Frequency/How often

Allergies, if so explain your REACTION: _____

Since your last full physical, have you had any new medical problems, hospitalizations, surgeries?

Are there any new medical problems in your family? Any births or deaths?

Please update:

Relationship Status: _____ for (how long) _____ to (name) _____ (male/female).	Occupation: _____
Sexually active? Yes / No	Hobbies: _____
Contraception/ Birth control: _____	Current recreational/illicit drug use: _____
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chew <input type="checkbox"/> Cigar	Alcohol Use: No/Yes Type: _____
Amount of Use: <input type="checkbox"/> Daily <input type="checkbox"/> Occasional	How many drinks per day? _____
Year Started: _____ Year Stopped: _____	Exercise (type): _____ (number) _____ times per week.
Packs per Day: _____ Cigars Per Week: _____	Caffeine use: How many drinks per day? _____
Cans per Week: _____	
Are you exposed to second-hand smoke? Yes/No	

Educational Level:

- Grade school
- High school
- College
- Graduate school
- Other: _____

CHILDREN:

NAME	GENDER (M/F)	AGE

Tests	Date	Results
Pap Smear		Normal / Abnormal
Mammogram		Normal / Abnormal
DEXA bone density		Normal / Abnormal
Colonoscopy		Normal / Abnormal
.....repeat date if known:		
Skin check		
Vision/eye exam		
Immunizations (Tdap, pneumonia, shingles, etc):		

Today's Date: _____



Name: _____ Date of Birth: _____

HEALTH HISTORY REVIEW- ADULT

Previous medical history: Check any conditions you have or have had in the past. Please write when it started, if known.

Eg. Asthma -Oct, 2010

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Chronic Renal Failure (CRF) | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Valvular Heart Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes-Type 1 | <input type="checkbox"/> Infertility | <input type="checkbox"/> U T I- Recurrent |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Diabetes- Type 2 | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Varicose Veins/Phlebitis |
| <input type="checkbox"/> Biliary Cirrhosis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Abnormal Pap Smear |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Deep Venous Thrombosis (DVT) | <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Breast Disease |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> G E R D | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Cervical Cancer |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> D E S Exposure |
| <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> High Cholesterol (Hyperlipidemia) | <input type="checkbox"/> Peripheral Vascular Disease (PVD) | <input type="checkbox"/> Diabetes-Gestational |
| <input type="checkbox"/> C O P D | <input type="checkbox"/> High Blood Pressure (Hypertension) | <input type="checkbox"/> Peptic Ulcer Disease (PUD) | <input type="checkbox"/> RH Sensitized |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hypothyroidism (underactive) | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Uterine Anomaly |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Hyperthyroidism (overactive) | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Sexually Transmitted Diseases/Infections: (name) _____ |

Surgical History (please note dates if known): Eg. Appendectomy -Jan, 2000

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Unremarkable | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Abd Surg-type | <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tunneled Dialysis Catheter |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Cesarean Section Birth | <input type="checkbox"/> Mitral Valve Replace | <input type="checkbox"/> Uvulopalatopharyngioplasty (UPPP) |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Nephrectomy: Native | <input type="checkbox"/> Urinary Incontinence Surgery |
| <input type="checkbox"/> Aortic Valve Replacement | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Nephrectomy: Transplant | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Craniotomy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> AV Fistula Creation | <input type="checkbox"/> Dental Surgery: _____ | <input type="checkbox"/> Parathyroidectomy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> AV Graft | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Pneumonectomy | |
| <input type="checkbox"/> BA-F Bypass | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Prostatectomy | |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Percutaneous Transluminal Coronary Angioplasty (PTCA) | <input type="checkbox"/> Anesthesia Prob- No |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Interventional Pain Procedures | <input type="checkbox"/> RA-F Bypass | <input type="checkbox"/> Anesthesia Prob- Yes |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Rotator Cuff Repair | <input type="checkbox"/> Surgical Complication- No |
| <input type="checkbox"/> Bilateral Tubal Ligation (BTL) | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Transurethral Resection of Prostate (TURP) | <input type="checkbox"/> Surgical Complication-Yes |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Total Hysterectomy (TAH) | <input type="checkbox"/> Post-op Delirium |
| <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> LA-F Bypass | <input type="checkbox"/> Oophorectomy (BSO) Right/Left/Both | |

MENSTRUAL/REPRODUCTIVE HISTORY (for girls and women):

Number of pregnancies: _____ # of births: _____ Miscarriages (Ab Spon): _____ Abortions (Ab Induc): _____

Age periods started (menarche): _____

Periods/menses occur about once a month?: YES/NO

Date last menstrual period started (LMP): _____

-OR- Menopausal since: _____

Indicate month/year of pregnancies:

Example	1	2	3	4	5	6
June 2008						

Problems with pregnancies or multiples? YES/NO

Today's Date: _____

Check any conditions you currently have:

GENERAL none

- fever
- chills
- sweats
- fatigue
- malaise
- unexplained weight loss
- unexplained weight gain
- excessive sleep
- inability to sleep

HEART/CARDIOVASCULAR none

- chest pains
- fast or irregular heartbeat (palpitations)
- fainting (syncope)
- difficulty breathing with exertion (dyspnea)
- difficulty breathing when lying down (orthopnea)
- shortness of breath that awakens you (PND)
- ankle or feet swelling
- varicose veins
- high blood pressures
- high cholesterol/triglycerides
- abnormal EKG
- heart murmur

RESPIRATORY none

- cough
- difficulty breathing (dyspnea)
- shortness of breath (orthopnea)
- excessive sputum
- coughing up blood (hemoptysis)
- wheezing

CHEST/BREASTS none

- lumps
- breast pain
- nipple discharge or bleeding
- change in size
- skin changes

ABDOMINAL/GASTROINTESTINAL none

- upset stomach (nausea)
- throwing up (vomiting)
- loose, watery stools (diarrhea)
- constipation
- change in bowel habits
- abdominal pain
- tarry or bloody stools (melena/hematochezia)
- yellowing of eye/skin (jaundice)
- loss of appetite (anorexia)
- vomiting blood (hematemesis)
- abdominal pain
- excessive gas
- bloating
- heartburn
- hemorrhoids

Name: _____

EYES none

- blurring
- double vision (diplopia)
- irritation
- discharge
- vision change, loss
- eye pain
- sensitivity to light (photophobia)

URINARY/GENITOURINARY none

- painful urination (dysuria)
- blood in urine (hematuria)
- urinary frequency
- loss of urine (incontinence)
- decreased interest in sex (libido)
- frequency
- hesitancy
- frequent nighttime urination (nocturia)
- genital sores
- impotence

SEXUAL none

- discuss birth control/contraception
- pain with sex (dyspareunia)
- skin changes or sores
- sexually transmitted diseases
- sexual difficulty

MALE

- discharge from penis
- swelling, pain in testicles
- impotence

FEMALE

- abnormal vaginal discharge
- skipped periods (amenorrhea)
- heavy periods (menorrhagia)
- abnormal bleeding
- pelvic/abdominal pain
- vaginal pain, irritation, itching
- abnormal pap smears
- hot flashes

MUSCULOSKELETAL none

- back pain
- joint pain
- joint swelling
- muscle cramps
- muscle weakness
- stiffness
- arthritis
- neck pain
- numbness
- limited motion
- abnormal X-ray

EARS/NOSE/THROAT none

- earache
- hearing loss
- sinus pain
- sore throat, hoarseness
- ear discharge
- ringing ears (tinnitus)
- decreased hearing
- nasal congestion (stuffy nose)
- nose bleeds
- trouble swallowing (dysphagia)

Date of Birth: _____

SKIN none

- rash
- itching
- dryness
- suspicious skin changes, lesions
- changes in moles
- hair or nail changes
- abnormal bruising

NEUROLOGICAL none

- temporary loss of muscle function (transient paralysis)
- weakness
- loss of sensation (paresthesias)
- seizures
- fainting (syncope)
- shakiness (tremors)
- dizziness (vertigo)
- headache
- concerning memory loss

MOOD/PSYCH none

- depression
- anxiety
- memory loss
- mental disturbance
- thoughts of hurting self (SI)
- seeing/hearing things (hallucinations)

ENDOCRINE none

- paranoia
- irritability
- concern for safety
- cold intolerance
- heat intolerance
- excessive thirst (polydipsia)
- excessive appetite (polyphagia)
- excessive urination (polyuria)
- weight change
- low blood sugar (hypoglycemia)
- thyroid problem

HEME/LYMPHATIC none

- abnormal bruising
- bleeding
- enlarged lymph nodes
- blood disorder
- anemia

ALLERGIC/IMMUNOLOGIC none

- hives (urticaria)
- hay fever, allergies
- persistent infections
- HIV exposure



Today's Date: _____

Name: _____ Date of Birth: _____

FAMILY History: Please indicate if family members have any of the conditions below, and indicate who.

Indicate MATERNAL = mother's side - or - PATERNAL = father's side, if known. Eg. paternal grandmother

Condition	Who	Condition	Who
Alcoholism		Angina	
Anesthesia Complication		Cervical Cancer	
Anemia		Heart Attack/Disease (CHD)	
Anxiety		in male under 55 yr?	
Arthritis		female under 65 yr?	
Asthma		Endometriosis	
Birth Defects, what?		Growth/Development Probs	
Bleeding Disorder		Headaches	
Breast Cancer		Lung Cancer	
Colon Cancer		Skin Cancer (Melanoma)	
Depression		Other Medical Problem	
Diabetes		Ovarian Cancer	
Heart Disease		PMS	
High Cholesterol		Psychiatric Care	
High Blood Pressure (Hypertension)		Uterine Cancer	
Kidney/Renal Disease		Weight Problems	
Lung/Respiratory Disease			
Migraines		Other? Please list:	
Osteoporosis			
Seizures			
Severe Allergies			
Stroke/TIA/CVA			
Thyroid Disorder			
Other Cancer			

Are there other concerns you would like to discuss today? (Your provider **may or may not have time** to discuss these things, or may prioritize certain concerns based on their clinical urgency. If we discuss or discover any additional problems, **you may be charged for an office visit, in addition to your physical.**)
