 Patient Label Here

**Patient Health History Form- COMPLETE PREVENTATIVE PHYSICAL**

**TODAY’S VISIT IS SCHEDULED AS A COMPLETE ROUTINE PREVENTATIVE VISIT.**

**NO PROBLEMS WILL BE ADDRESSED IN DETAIL IN TODAY’S VISIT.**

If this is a concern for you, please see front-desk to confirm that your appointment time with your provider will accommodate a problem-focused discussion in addition to your complete physical today. If this is not available, we will be glad to schedule a separate visit to discuss problems in detail or change today’s appointment focus.

**NOTE: This service is not a covered benefit by Medicare.**

Talk with the receptionist if you would like to change your appointment to the preventative service that Medicare will cover.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient acknowledgment

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name:** | | | | Today’s date: |
| **Gender** |  Male  Female | | **Birth date** (mm/dd/yy): | |
| **Currently Living:** | |  Alone  With family  With friends  With significant other | | |
| **Profession (Job):** | |  Currently working  Not currently working  Retired | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Health History** | | | | | | | |
| **Constitutional** | **No** | **Yes, Now** | **Yes, Past** | **Eye(s)** | **No** | **Yes, Now** | **Yes, Past** |
| Difficulty sleeping |  |  |  | Cataracts |  |  |  |
| Tiredness or Weakness |  |  |  | Glaucoma |  |  |  |
| Forgetfulness |  |  |  | **Ears, Nose &/or Throat** |  |  |  |
| Abnormal weight loss or gain |  |  |  | Ear infections |  |  |  |
| Alcohol or Chemical dependence |  |  |  | Sinus problems |  |  |  |
| **Respiratory** |  |  |  | Deafness, Dizzy or Ringing |  |  |  |
| Tuberculosis or Positive TB test |  |  |  | **Cardiovascular** |  |  |  |
| Shortness of breath |  |  |  | Abnormal EKG |  |  |  |
| Bronchitis, COPD or Emphysema |  |  |  | Heart attack or Heart disease |  |  |  |
| Asthma |  |  |  | Mitral valve prolapse |  |  |  |
| Cough (persistent or bloody) |  |  |  | Heart murmur |  |  |  |
| **Neurological** |  |  |  | High blood pressure |  |  |  |
| Headaches (frequent) |  |  |  | High cholesterol |  |  |  |
| Epilepsy or Seizures |  |  |  | Chest pain |  |  |  |
| Head injury |  |  |  | Circulatory problems |  |  |  |
| **Gastrointestinal** |  |  |  | Phlebitis or Blood clots |  |  |  |
| Gall stones |  |  |  | Stroke |  |  |  |
| Stool or Bowel problems |  |  |  | Rheumatic fever |  |  |  |
| Stomach problems or Ulcers |  |  |  | **Genitourinary** |  |  |  |
| Liver disease |  |  |  | Kidney or Bladder problems |  |  |  |
| Jaundice |  |  |  | **Musculoskeletal** |  |  |  |
| Hemorrhoid or Rectal problem |  |  |  | Arthritis or Sore joints |  |  |  |
| Hepatitis |  |  |  | Hernia |  |  |  |
| **Skin** |  |  |  | Broken bones |  |  |  |
| Psoriasis or Eczema |  |  |  | Gout |  |  |  |
| **Immunology** |  |  |  | **Psychological** |  |  |  |
| HIV/ AIDS |  |  |  | Depression and Sadness |  |  |  |
| **Hematological/ Allergy** |  |  |  | Anxiety |  |  |  |
| Cancer |  |  |  | Psychiatric care |  |  |  |
| Anemia |  |  |  | **Endocrine** |  |  |  |
| Bleeding or Bruising |  |  |  | Diabetes |  |  |  |
| Hay fever |  |  |  | Thyroid disease |  |  |  |

**Please turn over and complete other side**

|  |  |  |  |
| --- | --- | --- | --- |
| **Habits** | | | **Medications** |
| **Do you…** | | **If yes, how much?** | **List all medications, include non-prescription:** |
| Use cigarettes? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Chew tobacco? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Drink caffeine? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Drink alcohol? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Use street drugs? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Exercise? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Immunizations** | | | | **Allergies** |
| All appropriate-to-age immunizations completed | | |  Yes  No | List all allergies (including medicine, food, latex, etc.) |
| Pneumonia |  Yes  No | Date: | |  |
| Tetanus |  Yes  No | Date: | |  |
| Influenza |  Yes  No | Date: | |  |
| Shingles |  Yes  No | Date: | |  |

|  |  |
| --- | --- |
| **Hospitalizations (not including pregnancies)** | |
| Reason: | Year: |
| Reason: | Year: |
| Reason: | Year: |
| Reason: | Year: |

Pain or lumps in testicle(s)? Yes No N/A

Prostate disease or problems? Yes No N/A

Last prostate exam:\_\_\_\_ Abnormal? Yes No N/A

Problems start/stop urine stream? Yes No N/A

Wake while sleeping to urinate? Yes No N/A

Sexual problems or concerns? Yes No N/A

History of STD(s)/venereal disease? Yes No N/A Are you unsafe during intercourse? Yes No N/A

Last colonoscopy:\_\_\_\_\_\_ Abnormal? Yes No N/A

Last pap smear:\_\_\_\_\_\_\_ Abnormal? Yes No N/A

Last mammogram:\_\_\_\_\_\_ Abnormal? Yes No N/A

Age periods started:\_\_\_\_ Problems? Yes No N/A

Ovarian cysts? Yes No N/A

Birth control method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancies: # \_\_\_\_\_\_\_\_\_\_ Births: # \_\_\_\_\_\_\_\_\_\_

Do you have a living will? Yes No

Do you feel safe in your home? Yes No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Family History** | | | | | |
| **Disease** |  | **Relationship** | **Disease** |  | **Relationship** |
| Alcoholism |  Yes  No |  | Eye disease(s) |  Yes  No |  |
| Arthritis |  Yes  No |  | Heart attack |  Yes  No |  |
| Asthma |  Yes  No |  | High blood pressure |  Yes  No |  |
| Birth defects |  Yes  No |  | Kidney disease |  Yes  No |  |
| Cancer |  Yes  No |  | Mental illness |  Yes  No |  |
| Diabetes |  Yes  No |  | Migraines |  Yes  No |  |
| Epilepsy |  Yes  No |  | Stroke |  Yes  No |  |

**The information on this Patient Health History form is correct to the best of my knowledge.**

Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Acknowledges Review of this form** Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Patient Label Here

 INTERNAL STAFF USE ONLY 

|  |
| --- |
| **Physical Examination** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Body System** | **N/A** | **Normal** | **Abnormal** | **Body System** | **N/A** | **Normal** | **Abnormal** |
| 1. General |  |  |  | 8. Abdomen |  |  |  |
| 2. Skin |  |  |  | 9. Genito-urinary system |  |  |  |
| 3. Eyes |  |  |  | 10. Back/Spine |  |  |  |
| 4. Ears |  |  |  | 11. Extremities/joints |  |  |  |
| 5. Mouth/throat |  |  |  | 12. Neurological system |  |  |  |
| 6. Cardiovascular |  |  |  | 13. Integumentary/Breast(s) |  |  |  |
| 7. Lungs/chest |  |  |  | 14. Vascular system |  |  |  |

Procedures

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Female** | **N/A** | **Obtained** | **Male** | **N/A** | **Normal** | **Abnormal** |
| Pap Smear Collection |  |  | Prostate Examination |  |  |  |

*Discuss any abnormal answers in detail, along with the plan of care, in the space below.*

*Enter applicable item number before each comment.*

|  |
| --- |
| **Alternative:** Abnormal findings may be documented in the chart separately. |

|  |
| --- |
| **Screening Schedule** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Service** | **Recommended:** | **Recommended:** |  |
| Preventative exam (like this one) |  Annually |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Bone mass measurements |  Once every \_\_\_\_\_ yrs |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Cardiovascular screening blood tests (Total cholesterol, Lipids, Triglycerides) |  Once every \_\_\_\_\_ yrs |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Fecal occult test |  Annually |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Colonoscopy |  Once every \_\_\_\_\_ yrs |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Other colorectal CA screen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Fasting blood glucose |  Once every \_\_\_\_ mths |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Glaucoma screening |  Annually |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| HIV screening |  Annually |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Prostate CA screen (digital rectal exam or PSA) |  Annually |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Influenza shot |  Annually |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Pneumococcal shot |  Once a lifetime |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Hepatitis B |  Once a lifetime |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Mammography screening |  Annually |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| Pap test and pelvic exam screening |  Once every \_\_\_\_ yr(s) |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |
| AAA screening |  Once a lifetime |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  N/A |

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_