SUBLETTE COUNTY HEALTH

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: _____