Dates Reviewed: _____

Family Practice Associates
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Pre-Completed Physical Information

INSTRUCTIONS

Please ***complete prior*** to your complete physical appointment and ***bring with you*** at that time. (Please Print)

If you have completed this form before and have a prior report, use that report to help you complete this form. Mark (□) to no change when appropriate.

1. CONTACT INFORMATION • Please complete the following.

Initial Date of Appointment: _____

Name: _____ Date of Birth: _____ Age: ____ Sex: ____

Address: _____

Telephone: Home: _____ Cell: _____ Work: _____

2. EMERGENCY CONTACTS

Please list the name, relationship, and phone number(s) of two emergency contacts.

1. _____

Name Relationship Home # Cell #

_____

Work # Beeper #

2. _____

Name Relationship Home # Cell #

_____

Work # Beeper #

3. MEDICAL ALLERGIES • Please list all medical allergies—both the drug name and reaction.

☐ No change

Drug Name	Reaction

4. MEDICATION LIST • Please list all medications taken within the last year.

☐ No change

Name of Drug (including supplements & OTCs), strength, dose, & frequency	Date Started	Date Discontinued

5. HOSPITALIZATIONS • Please list all hospitalizations incurred within the last year.

☐ No change

Facility	Date of Visit	Attending Physician	Surgery?
			(Y / N)
			(Y / N)
			(Y / N)
			(Y / N)
			(Y / N)
			(Y / N)

6. SURGICAL HISTORY • Please list all past surgical history and include date & procedure. (Don't forget to include things like vasectomies, "tubes tied," tonsillectomy, etc.)

☐ No change

Procedure	Date of Visit	Complications?
		(Y / N)
		(Y / N)
		(Y / N)
		(Y / N)
		(Y / N)
		(Y / N)
		(Y / N)
		(Y / N)
		(Y / N)
		(Y / N)

If you answered yes to any complications above, please explain those complications in the space provided below:

7. HEALTH PROFESSIONALS • Please list any other health professionals you are currently consulting or have seen in the past (& would like to see again if needed.) This would include physicians, as well as dentist, osteopath, chiropractor, optometrist, ophthalmologist, GYN, etc.)

☐ No change

Physician	Specialty	Phone Number

1. FAMILY MEDICAL HISTORY

Please complete a family medical history. List all significant illness, past and present.

☐ No change

Biological Father: [Living / Deceased] Current Age (or Age at Death): _____

Cause of Death (if Deceased): _____

Medical Problems: _____

_____

_____

_____

Biological Mother: [Living / Deceased] Current Age (or Age at Death): _____

Cause of Death (if Deceased): _____

Medical Problems: _____

_____

_____

_____

Sibling: [M / F] Sibling is: _____ years [older / younger]

Medical Problems: _____

_____

Sibling: [M / F] Sibling is: _____ years [older / younger]

Medical Problems: _____

_____

Sibling: [M / F] Sibling is: _____ years [older / younger]

Medical Problems: _____

_____

Sibling: [M / F] Sibling is: _____ years [older / younger]

Medical Problems: _____

_____

2. SOCIAL HISTORY • Please complete the following social history.

☐ No change

Please circle one: [Single Married Divorced Widowed Separated]

Name of Spouse: _____ Number of Children: _____

Children:

First Name	Last Name	Age	Home Address (or City & State)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient's Occupation: _____ Hours a week dedicated to work: _____

Diet: (normal adult, diabetic, low fat, lactose intolerant, vegetarian, vegan, etc.)

_____

Caffeine use: [rare average significant] (please circle one)

Please list how many you drink daily: 1) coffee: _____ 2) tea: _____ 3) soft drinks: _____

Nicotine use: Include year you started, year you stopped (if applicable), what tobacco product you use, & how much you use (e.g. 1978 – present, cigarettes, one pack per day)

_____

Alcohol use: How much, how often, & what kind (e.g. one glass of wine daily)

_____

Drug use: ☐ Never ☐ Occasional ☐ Daily ☐ Prior use & Quit Date: _____

Drug names: _____

Seat belt usage: ☐ Never ☐ Sometimes ☐ Always

Hobbies/activities: _____

Home Environment: ☐ Private ☐ Assisted Living ☐ Other

3. IMMUNIZATIONS / PREVENTION:

	Date		Date
Flu Vaccine	_____	PPD	_____
TD (Tetnus / Diptheria)	_____	Hepatitis A series	_____
TDAP	_____	Hepatitis B series	_____
Pnemovax	_____	MMR	_____
Varicella	_____	Lymes Titer series	_____
Zoster (Shingles)	_____	Aspirin Therapy	_____
Meningococcal	_____	Dietary Counseling	_____
Gardisal (HPV)	_____	Calcium Supplements	_____

4. PROCEDURES OF INTEREST • Have you had these tests / exams before?

		Date	Comment / Explain
Complete physical exam:	[Y / N]	_____	_____
Pap Smear (if applicable):	[Y / N]	_____	_____
Mammogram (if applicable):	[Y / N]	_____	_____
Rectal exam:	[Y / N]	_____	_____
Prostate exam (if applicable):	[Y / N]	_____	_____
Dental exam:	[Y / N]	_____	_____
Flexible sigmoidoscopy:	[Y / N]	_____	_____
Colonoscopy:	[Y / N]	_____	_____
Stress test for the heart:	[Y / N]	_____	_____
Bone mineral density:	[Y / N]	_____	_____
Total abdominal ultrasound:	[Y / N]	_____	_____
Chest x-ray:	[Y / N]	_____	_____
EKG:	[Y / N]	_____	_____
Pulmonary Function Test:	[Y / N]	_____	_____
Cardiac Echocardiogram:	[Y / N]	_____	_____
Cholesterol check:	[Y / N]	_____	_____
Diabetes screening:	[Y / N]	_____	_____
Eye exam:	[Y / N]	_____	_____
Microalbumin:	[Y / N]	_____	_____
CT Scan **(head, chest, abdomen):**	[Y / N]	_____	_____
Microfilament exam:	[Y / N]	_____	_____

Initials of Reviewer: _____

5. UNUSUAL SYMPTOMS • Please mark down any unusual symptoms that you have been experiencing recently (3–6 months). Example: if your muscles hurt due to exercising, this might not be unusual. If they continue to ache without a clear cause, this would be reason to mark "muscle stiffness or pain."

General Symptoms

_____ Normal _____ Problems with sleep _____ Tired/Fatigued _____ Repeated Fevers

_____ Weight [Gain / Loss] • _____ pounds over a period of _____

Cardiovascular

___ Irregular heartbeat
___ Leg pain when walking any distance
___ Swelling feet or ankles
___ Palpitations or heart flutters
___ Marked fatigue
___ Recurrent lightheadedness
___ Chest pain
___ Other (list below)

_____

Endocrine Tract

___ Restlessness/hyperactivity
___ Excessive perspiration
___ Wounds slow to heal
___ Unusual thinning of hair
___ Cold extremities
___ Increased thirst
___ Increased body fat
___ Cold intolerance
___ Other (list below)

_____

Blood

___ Excessive or lengthy bleeding from cuts
___ Bruise easily
___ Swollen lymph nodes
___ Other (list below)

_____

Skin

___ Repeated rash
___ Scaling or oozing of the skin
___ Blistering or hives
___ Change in color
___ Painful moles
___ Itching
___ Unusual thinning of hair
___ Bleeding of the skin
___ Other (list below

_____

Urinary Tract

___ Burning or irritation
___ Increased urinary frequency
___ Blood in urine
___ Unable to hold up urine
___ Repeated mid-back pain
___ Other (list below)

_____

Eyes Ears Nose & Throat

___ Dizziness or whirling sensation
___ Failing vision
___ Double vision
___ Burning or tearing of the eyes
___ Pain in one or both eyes
___ Hearing Loss
___ Ringing sensation in ears
___ Pressure sensation in ears
___ Pain in one or both ears
___ Chronic sinus pressure/ congestion
___ Chronic nasal drainage
___ Repeated mouth sores
___ Hoarseness
___ Difficulty swallowing
___ Frequent cough
___ Bleeding when brushing teeth
___ Repeated swollen or tender gums
___ Increased number of cavities
___ Other (list below)

_____

UNUSUAL SYMPTOMS (Continued)

Gastrointestinal Tract

___ Diarrhea (repeated)
___ Vomiting (repeated)
___ Nausea
___ Difficulty swallowing
___ Indigestion (repeated)
___ Decreased appetite
___ Abdominal pain or cramping (repeated)
___ Constipation
___ Excessive Gas
___ Vomiting Blood
___ Rectal bleeding (blood in stool)
___ Jaundice or yellowing of skin
___ Other (list below)

_____

Musculoskeletal

___ Progressive joint stiffness
___ Joint swelling
___ Joint pain
___ Repeated neck pain
___ Repeated back pain
___ Muscle stiffness or pain
___ Muscle cramps or spasms
___ New mass or nodule of bone or muscle
___ Other (list below)

_____

Female Genital Tract

___ Irregular menstruation cycle
___ Vaginal discharge
___ Sores in genital region
___ Painful intercourse
___ Bleeding after intercourse
___ Breast discharge
___ Bleeding between periods
___ Swollen lymph nodes or knots in groin
___ Breast lump not previously evaluated
___ Other (list below)

_____

Male Genital Tract

___ Dribbling when urinating
___ Unable to hold up urine
___ Discharge from penis
___ Pain in testicle
___ Testicle swelling
___ Problems getting erection
___ Problems maintaining erection
___ Sores in genital region
___ Swollen lymph nodes or knots in groin
___ Other (list below)

_____

Nervous System

___ Recent headaches
___ Dizziness/spinning sensation
___ Unusual numbness/tingling
___ Hand, leg, or body tremors
___ Loss of balance, falling sensation
___ Increased forgetfulness
___ Back pain
___ Neck pain
___ Sudden changes in alertness
___ Repeated seizures
___ Fainting spells
___ Loss of consciousness
___ Loss of function of any body part
___ Other (list below)

_____

Mental Health

___ Mood Swings
___ Irritability / Anxiety
___ Depressed feelings
___ Problems with alcohol
___ Problems with drugs
___ Feelings of helplessness
___ Other (list below)

_____

* *

Thank you for completing your section. The following sections will be completed by your Family Practice Associates physician & staff.

* *

6. THIS SECTION TO BE COMPLETED BY OFFICE STAFF

_____	_____	_____
Staff conducting initial intake	Date of last exam	Medicare B eligibility date

_____

Language or other communication barriers (describe)

_____

Interpreter or other accommodation provided today (describe)

Vital signs:	_____	_____	_____	_____	_____	_____
	Ht	Wt	BMI / Waist	BP	Temp	P/R

_____	_____	_____	_____
LMP	Gravida / Para	Year of Menopause	Date of last pap smear

7. PROBLEM LIST

Chronic / Acute Problems	Date Added	Managing Physician (if other)	Date Updated	Initial
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

8. ELECTROCARDIOGRAM

Referral or Result if performed/ordered (covered benefit for IPPE)

9. VISION EXAMINATION

Visual Acuity:	
L:	R:

10. PHYSICIAN'S SIGNATURE

Physicians/other provider sign here to indicate review/notation of pertinent history.

_____

11. DEPRESSION SCREENING:

1. Over the past 2 weeks, has the patient felt down, depressed or hopeless? [Y / N]
2. Over the past 2 weeks, has the patient felt little interest or pleasure in doing things? [Y / N]

12. FUNCTIONAL ABILITY / SAFETY SCREENING

1. Was the patient's timed Up & Go test longer than 30 seconds? [Y / N]
2. Does the patient need help with the phone, transportation, shopping, preparing Meals, housework, laundry, medications or managing money? [Y / N]
3. Does the patient's home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? [Y / N]
4. Have you noticed any hearing difficulties? [Y / N]
5. Does patient have a steady gait? [Y / N]
6. Hearing Evaluation: [Y / N]

A "yes" response to any of the above questions regarding depression or function/safety should trigger further evaluation.

13. EVALUATION OF COGNITIVE FUNCTION (this documentation not required for IPPE)

Mood / Affect: _____

Appearance: _____

Family member / caregiver input: _____

14. ADVANCE CARE PLANNING (AT DISCRETION OF PATIENT)

1. Patient was offered the opportunity to discuss advance care planning: [Y / N]
2. Does patient have an Advance Directive? [Y / N]
3. If no, did you provide information on Caring Connections? [Y / N]

Notes & Plan:

15. ADVICE / REFERRALS (BASED ON HISTORY, EXAM AND SCREENING—INCLUDING RISKS, INTERVENTIONS UNDERWAY OR PLANNED AND BENEFITS)

_____

Initials of Reviewer