Dear Patient,

We look forward to seeing you for your wellness/physical exam. Thank you for giving us the opportunity to be a valued part of your health care.

We will be addressing your preventative health issues as well as any chronic medical issues you would like to discuss. We realize that completing this form takes about thirty minutes; however, it is very important that you complete this form in detail as it will expedite your exam process. If you have completed this form during a previous complete physical exam, use this form only to make any additions or corrections so that all information will be up to date. We appreciate your cooperation.

Please come prepared to have the necessary blood and laboratory testing performed by **fasting for eight to ten hours** before your exam. We encourage you to drink water before your exam. You may take your routine medications. We also ask that you do not apply lotions, powders or anything such as Vaseline that will prevent the EKG leads from adhering to your skin. Diabetics are advised to reduce your medication (either insulin and or pills) by half for that day.

During a wellness/physical exam, patients may receive several different services and each one may have a separate charge. Your insurance company may pay for some services; apply a copayment for some services, or state that some services are the patient's responsibility due to deductibles or screening/diagnostic testing not being covered. This is directly linked to your insurance plan. This is not a decision made by Family Practice Associates.

Your doctor will address additional questions and may need to provide additional services during your exam, if time and circumstances allow. Please be aware that if your physician addresses a new or established medical issue, your insurance company may be billed for the problem-oriented services provided in addition to preventative care which will result in a copayment due for the visit. By addressing these issues during the physical examination, we hope to avoid the inconvenience of asking you to return for a separate visit.

In this ever changing world of healthcare, it is important to know your health insurance coverage and payment policies as plans can vary greatly by employer and the policy selected.

Please call at least 24 hours in advance of your appointment if you need to reschedule. Should you have a question or concern, please contact the office. We look forward to seeing you soon…

DO I NEED TO PAY A “Co-Pay” TODAY

Your responsibility to pay a co-payment has changed with Healthcare Reform. The majority of Health Insurance Carriers eliminated patient co-payments for Preventative Screenings such as:

- Annual Preventative Visits and Well-Child Visits
- Mammograms
- Pap Smears
- Colonoscopies
- Vaccines (Depends on age and medical history)

You may be responsible for the payment of a co-payment or deductible during a preventative visit if the provider addresses a new, on-going or chronic issue or concern during your physical.

Examples of new issue or concerns are:

- Acute illness with or without fever
- Fatigue, Malaise or mood changes
- Pain: chronic or acute onset

Examples of on-going and /or chronic issues or concerns with or without refills are:

- Hypertension
- Diabetes
- High Cholesterol
- Depression

Insurance Carriers define preventative exams differently. Medicare does not provide the head to toe physical that commercial insurances may cover. Blood work and ancillary testing coverage varies according to your insurance plan. Please be aware that if your physician addresses a new or established medical issue that your insurance company may be billed for the problem-oriented services provided in addition to preventative care. This will create a financial responsibility for a copayment according to the contractual agreement with the insurance carrier.

Your insurance company may pay for some services; apply a copayment for some services, or state that some services are the patient's responsibility due to deductibles or screening/diagnostic testing guidelines. Any testing performed for new, on-going or chronic issues will be subject to your co-payment, co-insurance and/or deductible. This is directly linked to your insurance coverage and not a decision made by the providers here at Family Practice Associates.

As providers, we believe in comprehensive, quality care. By addressing your concerns or issues during the preventative/wellness exam, we hope to avoid the inconvenience of asking you to return for a separate visit.

Family Practice Associates

Dates Reviewed: _____

Family Practice Associates
13911 St. Francis Blvd. Suite 101 • Midlothian, Virginia 23114
Office: 804.320.3999 • Fax: 804.323.9383

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