Preventive and Problem Visits

Important information about charges and payments

If you are expecting to have a fully covered wellness exam only, please bring this to the attention of your practitioner at the beginning of your visit.
We practitioners often deal with, and patients often ask us to address, chronic or new problems while they are here for their preventive care/wellness visits. Usually most patients don't want to come back for another visit if their problems can be addressed while they are in the office.
In that case, we must charge for a wellness exam and a diagnostic exam on the same visit and patients must pay any co-pays or deductibles due for the diagnostic exam charge. Insurance policies require this. If the practitioner does not have time to deal with all the problems you bring up then they will ask you to schedule another visit.
We do our best to address all your needs while you are here but **if you do not want any charges for a diagnostic exam you must tell the practitioner at the beginning of your visit to only deal with preventive care** so they are aware of your wishes. If you have any chronic problems and/or identified symptoms that need attention the practitioner will then ask you to schedule a separate appointment at another time so as to limit the charges to just a wellness visit.

NAME date of birth age date of appointment

In order for us to provide you with effective medical care, we need to update some basic information about your past and present health. We also need to ask about your lifestyle because i physical and emotional well being. The questions on the next pages cover the topics we will discuss. Please answer them as best you can. Mark an X on the line following the word "No" c either describes your symptoms or history. Use a question mark when you don't understand a question or aren't sure of your answer. Thank you for completing this form

Before you start, please list all questions you have for the doctor:

Since your last visit have you had urgent care or a change in health? no ____ yes ____

If yes, what was it?

Has there been a change in the health of your mother, father, sisters, brothers, spouse, or children? no ____ yes ____

What was the change?

Please list all the medicines, tonics, and over-the-counter medicines, vitamins and supplements you take:

Name	strength	how often	for what

please bring all your bottles of medication to each appointment

Do you have any allergies to medications? Please list them and describe your reaction:

Which is your dominant side? (which hand do you write with?) Right Left

During the past year, have you:

1. had frequent headaches?	no ____	yes ____
2. felt dizzy, fainted or had blackouts?	no ____	yes ____
3. had seizures or convulsions?	no ____	yes ____
4. noticed any lumps on your body or swollen glands	no ____	yes ____
5. had eye trouble?	no ____	yes ____
6. had difficulty hearing?	no ____	yes ____
7. had troubles with your ears?	no ____	yes ____
8. had dental or other mouth problems?	no ____	yes ____
9. suffered from nose bleeds?	no ____	yes ____
10. suffered from allergies or hay fever?	no ____	yes ____
11. noticed any hoarseness in your voice?	no ____	yes ____

During the past year, have you:

12. been wheezing or been short of breath?	no ____	yes ____
13. had strange, persistent odors or tastes?	no ____	yes ____
14. frequently been coughing?	no ____	yes ____
15. sweated more than usual or had "night sweats"?	no ____	yes ____
16. had a racing heart or palpitations?	no ____	yes ____
17. had tightness or pains in your chest?	no ____	yes ____
18. had swollen feet or ankles?	no ____	yes ____

During the past year, have you had:

19. heartburn or indigestion?	no	yes
20. abdominal discomfort or pain?	no	yes
21. bouts of nausea or vomiting?	no	yes
22. difficulty swallowing?	no	yes
23. pains in your rectum?	no	yes
24. bowel movements that were bloody or tarry?	no	yes
25. any change in your bowel habits?	no	yes
26. If you are over 50, have you ever had sigmoidoscopy or Colonoscopy	no	yes
If yes, when?		
27. frequent urination during the day or at night?	no	yes
28. uncomfortable or difficult urination?	no	yes

For Men Only: During the past year, have you:

29. had a drip or discharge from your penis?	no ____	yes ____
30. noticed lumps or swellings on your testicles?	no ____	yes ____
31. had difficulty with your erection?	no ____	yes ____

For Women Only:

32 When was your last menstrual period?		
33. Was it normal?	yes ____	no ____
34. number of days between periods		
35. Length of bleeding, in days		

NAME date of birth Appointment date

36. If you are past menopause, have you had vaginal bleeding? no ____ yes ____

If you are past your meonpause, please skip to question 39

37. Has there been any change in your periods? no ____ yes ____
38. Have you noticed bleeding between your periods? no ____ yes ____
39. Do you have discomfort during intercourse? no ____ yes ____
40. Do you bleed from your vagina after intercourse? no ____ yes ____
41. Do you have any vaginal itching, burning or discharge? no ____ yes ____
42. discomfort or pain in your pelvis? no ____ yes ____
43. problems with your breasts? no ____ yes ____
44. When was your last Pap test? ____
45. Have you ever had an abnormal Pap test? no ____ yes ____
46. Have you ever had an abnormal mammogram? no ____ yes ____
47. Date of last mammogram: ____

For Both Men and Women, During the past year have you:

48. had any skin problems or noticed any changes in your skin or glands? no ____ yes ____
49. Do you use sunscreen routinely? yes ____ no ____
50. had aching muscles or joints? no ____ yes ____
51. had leg cramps? no ____ yes ____

During the past year, have you:

52. felt exhausted or fatigued most of the time? no ____ yes ____
53. felt "blue", lonely or depressed? no ____ yes ____
54. been more irritable than usual? no ____ yes ____
55. had frequent crying spells or felt like crying? no ____ yes ____
56. had difficulty trying to calm down or relax? no ____ yes ____
57. been overly anxious or been worrying a lot? no ____ yes ____
58. felt that you or others would be better off if you were dead? no ____ yes ____
59. desired or sought counseling? no ____ yes ____

Eating, Drinking, and Environmental:

60. Do you use salt at the table? no ____ yes ____
61. Has your appetite noticeably changed in the past month? no ____ yes ____
62. Have you gained/lost 10 or more pounds in the past 6 months? no ____ yes ____
63. Do you drink caffeinated coffee, tea or soda? no ____ yes ____
    How much? ____
64. Do you smoke or use tobacco now? no ____ yes ____
65. If you stopped some time ago, when was it? no ____ yes ____
66. Do you drink more than 2 alcoholic bevarages a day? no ____ yes ____
67 Have you ever felt you ought to cut down on your drinking or drug us no ____ yes ____
    -ever been annoyed by people criticizing your drinking or drug use? no ____ yes ____
    -ever felt bad or guilty about your drinking or drug use? no ____ yes ____
    -ever had a morning "eye opener" to steady your nerves? no ____ yes ____
68. Are you or have you used prescription drugs without having a prescription? no ____ yes ____
    - ever used other "recreational" drugs? no ____ yes ____
69. What is the age of your home? ____
70. Has your home been tested for radon? no yes

71. Have your pets been vaccinated for rabies? yes ____ no ____
72. Do you have a Living Will and Health Care Proxy filed with us? yes ____ no ____

Work and Play:

73. Are you generally satisfied with your work? yes ____ no ____
74. What kinds of exercise do you do? ____
75. What are your hobbies or leisure activities? ____
76. In what kinds of groups, organization, or community activities do you participate? ____
77. List the countries that you have visited in the past 6 months ____
78. Do you usually wear safety belts when riding in a car? yes ____ no ____
79. Are there any guns in your house? no ____ yes ____
    What type? ____
    Are they locked up? yes ____ no ____
80. Are there smoke detectors in your house? yes ____ no ____

Sexuality:

81. Are you sexually active now? yes ____ no ____
82. Are you generally satisfied with sex? yes ____ no ____
83. What do you do for family planning or birth control? ____
84. Do you have sexual concerns? no ____ yes ____
85. In the last 5 years how many sexual partners have your had? ____
86. Would you like an HIV test? no ____ yes ____
87. Do you use or have contact with anyone who uses IV drugs? no ____ yes ____

Family Apgar Assessment

"Family" here refers to the relatives or close friends with whom you usually live or look to for continuing emotional support.

Are you satisfied with the way your family:

88. - helps you when you are in trouble? yes ____ no ____
89. - discusses things and shares your problems? yes ____ no ____
90. - accepts your new interests or changes in your lifestyle? yes ____ no ____
91. - expresses affection and responds to your feelings or moods? yes ____ no ____
92. - spends time together with you? yes ____ no ____
93. Are you concerned about physical violence or possible incest in your family? no ____ yes ____

Social Support

94. Is your time well balanced between your work, family, and leisure activities? yes ____ no ____
95. Is your relationship with your friends as good as it was last year? yes ____ no ____
96. Is your relationship with your spouse/partner as good as it was last year? yes ____ no ____
97. Is there someone with whom you can always discuss your personal problems? yes ____ no ____
98. Would you like patient education on any topics? no ____ yes ____
    What topics? ____
99. Do you ever feel unsafe at home? yes ____ no ____
100. Has anyone at home hit or tried to injure you in any way? yes ____ no ____