

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 _____

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 it affects your 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" or "Yes" when 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 _____

36. If you are past menopause, have you had vaginal bleeding? no ___ yes ___
 If you are past your menopause, 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 beverages a day? no ___ yes ___
 67. Have you ever felt you ought to cut down on your drinking? no ___ yes ___
 -ever been annoyed by people criticizing your drinking? no ___ yes ___
 -ever felt bad or guilty about your drinking? 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 you 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 ___