Patient Name_________________________________ MRN______________ Date _________________

# Physical Exam Waiver

Dear Patient:

You are scheduled today for your Annual Preventative Medicine visit, also referred to as an Annual Physical.

Please know that your insurance may only cover this service once every 365 days. If you have received this service from another provider in the last 375 days you may be charged for this visit.

The Annual Preventative Medicine visit includes the following:

- An age focused history and exam that is not part of disease management.
- Counseling, guidance and risk factor reduction.
- Ordering of routine tests such as screening colonoscopy, screening labs, and radiological services to identify potential problems.

The Annual Preventative visit does not include the below services. If you require these services today, please be aware your insurance may require that you pay a copay for today's visit. Please let your provider know if you do not want these services.

- Evaluation and or management of new or ongoing problems that would require further testing or discussion. This may include a more problem focused physical exam, ordering of diagnostic tests, prescription drug management, referring or discussing your case with another specialist, or simply providing counseling related to a known health issue.

If you have any questions regarding this information, please see the front desk staff.

I have read and understand this information:

Patient Signature_________________________________________ Date _______________________

Patient Name_________________________________ MRN______________ Date _________________

# For Woman:

Preventative Health History: Please circle or write in your answer

| Question | Answer | | |
|---|---|---|---|
| Have you ever had a transfusion or blood exposure? | Yes | No | |
| When was your last tetanus shot? | | | |
| Have you had a flu shot in the last year? | Yes | No | |
| Have you had a colonoscopy | Yes | No | |
| When was last PAP smear? | | | |
| Have you had an abnormal PAP smear? | Yes | No | When? |
| Have you ever had a mammogram? | Yes | No | |
| Was last mammogram normal? | Yes | No | Why? |

Menstrual History:

| Question | Answer | |
|---|---|---|
| Do you have any bleeding or spotting? | Yes | No |
| Date of last menstrual period: | | |

Pregnancy History:

1. Number of pregnancies: _______________
2. Number of live births: ________________
3. Number of miscarriages: _______________
4. Number of abortions: _________________
5. Number of ectopic (tubal pregnancies)___________

Sexual History:

1. Have you had sex with [ ] Men [ ] Women [ ] both [ ] never sexually active [ ] not currently

2. Are there any problems or anything else you want to discuss? Yes No

2. Contraception:
   Birth control pills [ ] condoms [ ] DepoProvera [ ] Diaphragm [ ] Foam/Jelly [ ] IUD [ ] none [ ] NuvaRing [ ] Patch [ ] Rhythm method [ ] Subcutaneous Implants [ ] Tubal ligation [ ] Withdrawal [ ] Post-menopausal [ ]

Patient Name__________________________________ MRN______________ Date _________________

**General Health (CONSTITUTIONAL)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Fever: | Yes | No |
| Chills: | Yes | No |
| Sweats: | Yes | No |
| Loss of Appetite: | Yes | No |
| Fatigue: | Yes | No |
| Feeling unwell: | Yes | No |
| Weight Loss: | Yes | No |

**Lungs (RESPIRATORY)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Cough: | Yes | No |
| Shortness of breath: | Yes | No |
| Wheezing: | Yes | No |
| Blood in sputum: | Yes | No |
| Excessive sputum: | Yes | No |
| Pain when taking a Deep breath: | Yes | No |

**Heart (CARDIOVASCULAR)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Chest pain: | Yes | No |
| Palpitations: | Yes | No |
| Swelling: | Yes | No |
| Shortness of breath On exertion: | Yes | No |
| When lying down: | Yes | No |
| When sleeping: | Yes | No |
| Fainting: | Yes | No |

**Ears nose and throat**

**Recently have you experienced?**

| | | |
|---|---|---|
| Ear pain: | Yes | No |
| Loss of hearing: | Yes | No |
| Runny nose: | Yes | No |
| Sore throat: | Yes | No |
| Ear discharge: | Yes | No |
| Ringing in the ears: | Yes | No |
| Sinus congestion: | Yes | No |
| Nosebleeds: | Yes | No |
| Sinus pain: | Yes | No |
| Trouble swallowing: | Yes | No |
| Hoarseness: | Yes | No |
| Snoring: | Yes | No |

**Skin (INTEGUMENTARY)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Rash: | Yes | No |
| Itching: | Yes | No |
| Skin changes: | Yes | No |
| Dryness: | Yes | No |

**Eyes**

**Recently have you experienced?**

| | | |
|---|---|---|
| Blurriness: | Yes | No |
| Double vision: | Yes | No |
| Vision loss: | Yes | No |
| Pain: | Yes | No |
| Redness: | Yes | No |
| Discharge: | Yes | No |
| Sensitivity to light: | Yes | No |

**Stomach (GASTROINTESTINAL)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Nausea: | Yes | No |
| Vomiting: | Yes | No |
| Diarrhea: | Yes | No |
| Abdominal pain: | Yes | No |
| Constipation: | Yes | No |
| Changes in bowel habits: | Yes | No |
| Vomiting blood: | Yes | No |
| Blood in the stool: | Yes | No |
| Yellowing of skin: | Yes | No |
| Black tarry stools: | Yes | No |
| Heart burn: | Yes | No |

**Muscles and Joints (MUSCULOSKELETAL)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Joint swelling: | Yes | No |
| Joint pain: | Yes | No |
| Muscle pain: | Yes | No |
| Back pain: | Yes | No |
| Muscle cramps: | Yes | No |
| Muscle weakness: | Yes | No |
| Stiffness: | Yes | No |

**Head (NEUROLOGICAL)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Dizziness: | Yes | No |
| Headache: | Yes | No |
| Strange sensations: | Yes | No |
| Poor balance: | Yes | No |
| Seizures: | Yes | No |
| Paralysis: | Yes | No |
| Tremors: | Yes | No |
| Muscle weakness: | Yes | No |

**Bladder/Genitals (GENITOURINARY)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Painful urination: | Yes | No |
| Urinary urgency: | Yes | No |
| Urinating allot: | Yes | No |
| Decreased Libido: | Yes | No |
| Discharge: | Yes | No |
| Genital sores: | Yes | No |
| Blood in the urine: | Yes | No |
| Difficulty urinating: | Yes | No |
| Impotence: | Yes | No |
| Incontinence: | Yes | No |
| Urinating at night: | Yes | No |

**For Woman: Breasts**

**Recently have you experienced?**

| | | |
|---|---|---|
| Swollen lymph nodes: | Yes | No |
| Dimpling: | Yes | No |
| Itching: | Yes | No |
| Breast Mass: | Yes | No |
| Nipple discharge: | Yes | No |
| Nipple inversion: | Yes | No |
| Breast pain: | Yes | No |

**Mental State (PSYCHIATRIC)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Anxiety: | Yes | No |
| Depression: | Yes | No |
| Hallucinations: | Yes | No |
| Mood swings: | Yes | No |
| Over sleeping: | Yes | No |
| Insomnia: | Yes | No |
| Memory loss: | Yes | No |
| Mental disturbance: | Yes | No |
| Paranoia: | Yes | No |
| Suicidal thoughts: | Yes | No |

**Hormones (ENDOCRINE)**

**Recently have you experienced?**

| | | |
|---|---|---|
| Cold intolerance: | Yes | No |
| Hair changes: | Yes | No |
| Heat intolerance: | Yes | No |
| Feeling very thirsty: | Yes | No |
| Increased appetite: | Yes | No |
| Increased urination: | Yes | No |
| Thyroid swelling: | Yes | No |
| Weight changes: | Yes | No |

**Hematologic**

**Recently have you experienced?**

| | | |
|---|---|---|
| Bruising: | Yes | No |
| Bleeding: | Yes | No |
| Enlarged Lymph nodes: | Yes | No |

**Allergic/ Immunologic**

**Recently have you experienced?**

| | | |
|---|---|---|
| Repeated Infections: | Yes | No |
| Seasonal allergies: | Yes | No |
| Food allergies: | Yes | No |
| Unusual rashes: | Yes | No |

Patient Name________________________________ MRN_____________ Date ________________

1. During the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless?
   ❑ Yes ❑ No
2. During the past 2 weeks, have you often been bothered by little interest or pleasure in doing things?
   ❑ Yes ❑ No

## Patient Health Questionnaire (PHQ-9)

**If you have answered yes to any of the questions above please continue if not STOP**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself- or that you are a failure of have let yourself or your family down. | 0 | 1 | 2 | 3 |
| 7. Trouble Concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| 10. How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

Add columns _______ + ________ + ________

TOTAL: ________________________

Patient Signature: ________________________________________________ Date_________________________

Provider Signature: _______________________________________________ Date _________________________

**Scan under "Health Assessment Tools > PHQ 9"**