Comprehensive Health Assessment

Patient's full name: ____

Patient's date of birth: _____________ (mm/dd/yyyy)

Dear Patient,

We thank you for giving us the opportunity to help serve you and your health needs. This is more than just a physical examination. We believe that it is an integral component of excellent medical care. For this reason, we ask that you fill out an extensive questionnaire that will help us to better care for your specific health needs. Our assessment and treatment will only be as good as the information you supply to us, so please take time to answer each question thoroughly and thoughtfully.

You will need to schedule a follow-up exam three to four weeks after this initial physical. During that appointment we will go over the results of the tests performed and answer any additional questions you may have. Remember, your health is your responsibility. Our job is to be your health resource, ally and advocate.

Please bring this entire packet with you on the day of your appointment and don't forget to fast* for 12 hours prior to your physical. (*black coffee or water only). Please avoid body lotions and deodorants as well.

Please be aware that your insurance may or may not cover your annual exam. Some payers do not cover what they consider 'preventative' care and of those that do, coverage varies. Most insurance require exams to be done no more than once every 12 months. Our doctors do not base their care on what insurance plans dictate, but on what is good medical care. This office will not code an exam differently in order to get payment. Please do not ask us to disguise a preventative exam as a problem visit in order to ensure coverage. If insurance fails to cover the exam, you will be responsible for the charges. Please note that we do not run a precertification on your insurance prior to your appointment, that you may be asked to sign a payment agreement if you cannot prove coverage, and we will not file insurance claims for tests that are sent to labs outside of our office such as: pap smears, cultures, and certain blood tests. Please make sure that our physician is contracted with your insurance and a member of your network before making an appointment. Please take an active role in your healthcare by being well-informed about your plan, its coverage and its limitations. Also, keep in mind that in most cases, you must receive a referral from your Primary Care Doctor before you may go see an in-network specialist. The referral process normally requires an office visit and at least 72 hours for completion.

Please sign this form, stating that you have read and understood the above information.

____ __________

Patient's Signature Date

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Please answer the following questions as thoroughly as possible.

1. Why are you getting a physical examination?
   Routine Spouse/family member is concerned
   Personal health concerns Doctor suggested Other

   ____
   ____

2. Please list any medications, including prescription or over-the-counter, that you are allergic to or have reacted to, and explain.

   ____
   ____
   ____
   ____

Are there any other substances to which you react? Yes No What was the reaction?

   ____
   ____

3. Please indicate if you or any blood relatives suffer or have suffered any of the conditions listed below. Circle the conditions that apply and list the family member in the space provided. (Immediate blood relatives include parents, siblings and any other close family members who the condition appears in frequently)

Alcoholism or drug abuse ____

Anemia ____

Arthritis/Rheumatism ____

Attention Deficit Disorder ____

Cancer ____

Crohn's Disease/ Colitis ____

Depression/Mental Illness ____

Diabetes ____

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Eczema/Hives/Rash/Skin Conditions ____

Glaucoma ____

Heart Disease (angina, heart attack, heart failure, etc.) __________________________________

Heart Disease (Congenital/inherited) ____

Hemophilia (free bleeding) ____

Hepatitis/Jaundice ____

High Blood Pressure ____

Lung (asthma, emphysema, cancer, etc.) ____

Lupus, Scleroderma, Auto-immune Disease ______________________________________

Mumps, Measles, Chicken Pox ____

Nephritis/Kidney Disease ____

Nervous Breakdown ____

Phlebitis (blood clots) ____

Rheumatic Fever ____

Rubella (German Measles) ____

Seizures/Epilepsy ____

Stroke ____

Suicide ____

Thyroid Disease ____

Ulcers ____

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4. Hospitalizations/Surgeries

Please list any hospitalizations you have had for surgery or major illness. Include day surgery and psychiatric inpatient care or rehabilitation and the approximate dates.

1) ____ date: __________

2) ____ date: __________

3) ____ date: __________

4) ____ date: __________

5) ____ date: __________

6) ____ date: __________

7) ____ date: __________

8) ____ date: __________

5. Medications/Remedies

Please list all medications you currently take on a daily basis, as well as those you take 'as needed'. Include both prescription, over-the-counter, herbal and natural remedies. Please include the strength/dose of the medication, the form of the medication (pill, ointment, liquid, patch, etc) and how frequently you take it. (Please include hormones, birth control prescriptions, homeopathic remedies and natural supplements)

____

____

____

____

____

____

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6. System Review

You would best describe your health as:

Best ever   Excellent   Good   Acceptable
Worrisome   Poor   Failing

Please describe.

____

____

____

Please select the symptoms that apply to each area of the body and circle the number that corresponds to the level of severity:

Ears/Nose/Throat: hearing changes, ringing in the ears, ear pain/discharge, sinus problems, nasal congestion, sore throat, difficulty swallowing, hoarseness, facial pain

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

Head/Neck: headaches, migraines, stiff neck, swollen glands

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

Lungs/Breathing: cough, wheezing, shortness of breath, pain w/ breathing

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

Heart/Vascular: chest pain/pressure, racing heart, palpitations (fluttering), shortness of breath w/ exertion, high blood pressure, swollen feet, frequent nighttime urination, varicose veins, phlebitis, poor circulation

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

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Perisseia Primary Care and Wellness

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Breast health: lump, pain, discharge   Date of Last Mammogram: ___________

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

Gastrointestinal: nausea, vomiting, indigestion, heartburn, pain
cramping, diarrhea, constipation, change of appetite
black/dark/bloody bowel movements, hemorrhoids

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

Urinary Tract: difficult or painful urination, excessive or frequent urination
blood in urine, dark/discolored/cloudy urine

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

Genital (men): testicular pain or lump, hesitant/dribbling urination
frequent nighttime urination, abnormal discharge, sexual difficulties
sexually transmitted disease.   Do you examine your testicles for lumps?   Y   N

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

Genital (women): Spotting, irregular or excessive bleeding, cramping,
abnormal discharge, itching, pain w/ intercourse, sexually transmitted disease

0 - not present   1 - present, no limitation   2 - slight limitation
3 - limited function   4 - disabling

Age at first menstrual period ______
First day of last normal menstrual period ___________
Length of entire cycle _____________
Menopause at age _____________   Have you had tubal ligation?   Y   N
Hysterectomy?   Y   N   If yes, were your ovaries removed?   Y   N
Last Pap Smear ____________
History of abnormal pap smear?   Y   N   If yes, when? ___________

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Obstetrical: (Please write the number in the appropriate blanks)

Pregnancies ________ Live births ________ Miscarriages ________ Abortions ________
Number of living children ________ Premature births ________ C-Sections ________

Muscular/Skeletal: bone or joint pain, stiffness, swelling, weakness,
deformity, limited rage of motion, muscle spasms

0 - not present 1 - present, no limitation 2 - slight limitation
3 - limited function 4 - disabling

Skin/Hair: change in moles or warts, rashes, acne, easy bruising,
peeling/scaling skin, hair loss, unwanted hair growth, spots or darkening of skin,
loss of skin color/pigment

0 - not present 1 - present, no limitation 2 - slight limitation
3 - limited function 4 - disabling

Neurological: seizures or blackouts, tremors, dizziness or vertigo, memory lossconfusion,
loss of consciousness, behavior change, weakness,
loss of sensation (touch, taste, smell, pain, etc), weakness, numbness,
loss of vision

0 - not present 1 - present, no limitation 2 - slight limitation
3 - limited function 4 - disabling

Mental/Emotional: mood swings, crying, health worries,
anxiety or nervousness, poor memory, difficulty concentrating
suicidal thoughts or plans, short temper, depression, insomnia

0 - not present 1 - present, no limitation 2 - slight limitation
3 - limited function 4 - disabling

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Lifestyle:

Do you smoke? Y N How often/much? ___________________________________

Live with a smoker? Y N How long ago & duration _____________________________

Do you drink? Y N How often/much? ___________________________________

Have you had any change in appetite, weight, or hours of sleep?

____

____

Are you dealing with any life-changing stresses?
(Marital, job, financial, family, other)

0 - not present 1 - present, no limitation 2 - slight limitation
3 - limited function 4 - disabling

Please list any other concerns you may have or questions you would like to address in the exam.

____

____

____

____

____

By signing this form I acknowledge my part and responsibility in my healthcare and that an accurate health assessment depends, to a large extent, on the information I supply to my physician. I acknowledge that the information I have supplied here is true and complete to the best of my knowledge.

____ ___________

Patient's Signature Date

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