

Dates Reviewed: _____



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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 #

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)

8. ELECTROCARDIOGRAM

Referral or Result if performed/ordered (covered benefit for IPPE)

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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:

- Over the past 2 weeks, has the patient felt down, depressed or hopeless? [Y / N]
- Over the past 2 weeks, has the patient felt little interest or pleasure in doing things? [Y / N]

12. FUNCTIONAL ABILITY / SAFETY SCREENING

- Was the patient's timed Up & Go test longer than 30 seconds? [Y / N]
- Does the patient need help with the phone, transportation, shopping, preparing Meals, housework, laundry, medications or managing money? [Y / N]
- 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]
- Have you noticed any hearing difficulties? [Y / N]
- Does patient have a steady gait? [Y / N]
- 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)

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Initials of Reviewer