

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Medications \_\_\_\_\_

Allergies \_\_\_\_\_ Birth control method \_\_\_\_\_

**Hospitalizations or Surgeries:**

Date:	Surgery or reason for hospitalization:

<p><b>Menstrual history</b>          First day of last period _____          How many days does your period last? _____          Days from the start of one period until the next _____          Age period began _____ Age period ended _____</p>	<p><b>Pregnancy history</b>          Number of pregnancies _____          Dates of pregnancies _____          Number of miscarriages _____          Number of abortions _____</p>
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**Date of:** last pap smear \_\_\_\_\_ last mammogram \_\_\_\_\_ last bone density test \_\_\_\_\_

**Family history: Please indicate whether immediate relatives (parents, children, grandparents, aunts/uncles) have had any of the following:**

Breast cancer _____	High cholesterol _____	Alzheimer's disease _____
Ovarian cancer _____	High blood pressure _____	Depression _____
Cervical cancer _____	Heart attack _____	Anxiety _____
Uterine cancer _____	Aneurysms _____	Thyroid disease _____
Skin cancer _____	Stroke _____	Alcoholism _____
Colon cancer _____	Osteoporosis _____	Diabetes _____
Other cancer _____		

**Social History:** I live with \_\_\_\_\_ Marital status \_\_\_\_\_ Occupation \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Packs per day \_\_\_\_\_ Do you drink? \_\_\_\_\_ Drinks per week \_\_\_\_\_ Do you use drugs? \_\_\_\_\_

**Health problems or concerns. Mark "C" for current problems and "X" for past problems.**

<p><b>General</b>  <input type="checkbox"/> Cancer  <input type="checkbox"/> Anemia  <input type="checkbox"/> Blood clot in lungs or leg  <input type="checkbox"/> Eating disorder  <input type="checkbox"/> Unusual fatigue  <input type="checkbox"/> Abnormal thirst  <input type="checkbox"/> Sleeping problems  <input type="checkbox"/> Skin trouble  <input type="checkbox"/> Back pain</p> <p><b>Neurological</b>  <input type="checkbox"/> Frequent headaches  <input type="checkbox"/> Fainting spells  <input type="checkbox"/> Seizures  <input type="checkbox"/> Dizzy spells  <input type="checkbox"/> Depression or anxiety</p> <p><b>Neck</b>  <input type="checkbox"/> Goiter  <input type="checkbox"/> Lump  <input type="checkbox"/> Pain or stiffness</p>	<p><b>Heart</b>  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Heart murmur  <input type="checkbox"/> Heart attack/problems  <input type="checkbox"/> Stroke  <input type="checkbox"/> Shortness of breath  <input type="checkbox"/> Night sweats  <input type="checkbox"/> Chest pain or pressure  <input type="checkbox"/> Palpitation or fluttering  <input type="checkbox"/> Swollen ankles</p> <p><b>Lungs</b>  <input type="checkbox"/> Asthma  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Chronic cough</p> <p><b>Breast</b>  <input type="checkbox"/> Lump  <input type="checkbox"/> Discharge  <input type="checkbox"/> Pain</p>	<p><b>Intestinal</b>  <input type="checkbox"/> Ulcers  <input type="checkbox"/> Bowel problems  <input type="checkbox"/> Hepatitis  <input type="checkbox"/> Gallbladder problems  <input type="checkbox"/> Loss of appetite  <input type="checkbox"/> Nausea or vomiting  <input type="checkbox"/> Vomiting of blood  <input type="checkbox"/> Pain in abdomen  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Blood in stools  <input type="checkbox"/> Black, tarry stools</p> <p><b>Pelvic and genital</b>  <input type="checkbox"/> Endometriosis  <input type="checkbox"/> Fibroids  <input type="checkbox"/> Chlamydia or gonorrhea  <input type="checkbox"/> Herpes  <input type="checkbox"/> Abnormal pap smear  <input type="checkbox"/> Pelvic pain  <input type="checkbox"/> Irregular periods  <input type="checkbox"/> Painful periods  <input type="checkbox"/> Hot Flashes  <input type="checkbox"/> Vaginal discharge  <input type="checkbox"/> Vaginal irritation</p>	<p><b>Urinary</b>  <input type="checkbox"/> Kidney infections/stones  <input type="checkbox"/> Bladder infections  <input type="checkbox"/> Frequent urination  <input type="checkbox"/> Pain with urination  <input type="checkbox"/> Urine leakage  <input type="checkbox"/> Blood in urine</p> <p><b>Endocrine</b>  <input type="checkbox"/> Thyroid disease  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Osteoporosis</p> <p><b>Extremities</b>  <input type="checkbox"/> Arthritis, joint pain  <input type="checkbox"/> Varicose veins  <input type="checkbox"/> Broken bones</p> <p><b>Any other illnesses or symptoms:</b>          _____</p>
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**Do you have any special problems or concerns today that are not listed above?** \_\_\_\_\_

Thank you for taking the time to complete this questionnaire. It will allow us to more completely address your needs and concerns.



- Obstetrics
- Gynecology
- Family Medicine

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Dear Patient,

The **Annual Physical Exam for Males** done by our physicians includes a comprehensive history (medical, surgical, family, social) risk factor identification, medication review and a complete physical exam.

Many insurance companies classify some of these services as preventative (i.e. cholesterol screening, urinalysis screening, colon cancer screening, diabetic screening, family history risk factor identification and others). These insurance companies may not pay for these services depending on the policy you have chosen.

We understand that not every patient has coverage for a comprehensive annual exam, but we are required by law to report accurately the services rendered at any given patient encounter. Your insurance company requires that we comply with all of their rules and regulations.

**In the event that your insurance company does not cover preventative exams, you will be responsible for this portion of the bill.**

In light of this, we are establishing the following policy in our office, effective immediately. **All examinations scheduled as annual examinations will be billed to your insurance company as a preventative service, not a “sick patient” service.** If you have a problem that needs to be taken care of immediately, please make a separate appointment.

If this is a concern to you, please discuss this with your doctor **AT THE BEGINNING** of your appointment.

I have read and *agree* with the above.

Signature\_\_\_\_\_

Date\_\_\_\_\_

I have read and *disagree* with the above.

Signature\_\_\_\_\_

Date\_\_\_\_\_