

Name _____ Age _____ Date _____

Medications _____

Allergies _____ Birth control method _____

Date of last physical exam _____

Hospitalizations or Surgeries:

Date:	Surgery or reason for hospitalization:

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 _____
Prostate cancer _____	High blood pressure _____	Depression _____
Testicular cancer _____	Heart attack _____	Anxiety _____
Skin cancer _____	Aneurysms _____	Thyroid disease _____
Colon cancer _____	Stroke _____	Alcoholism _____
Other cancer _____	Osteoporosis _____	Diabetes _____

Social History: I live with _____ Marital status _____ Occupation _____

Do you smoke? _____ Packs per day _____ Do you drink? _____ Drinks per week _____ Do you use drugs now or in the past? _____

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

<p>General</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Blood clot in lungs or leg</p> <p><input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> Unusual fatigue</p> <p><input type="checkbox"/> Abnormal thirst</p> <p><input type="checkbox"/> Sleeping problems</p> <p><input type="checkbox"/> Skin trouble</p> <p><input type="checkbox"/> Back pain</p> <p>Neurological</p> <p><input type="checkbox"/> Frequent headaches</p> <p><input type="checkbox"/> Fainting spells</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Dizzy spells</p> <p><input type="checkbox"/> Depression or anxiety</p> <p>Neck</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Lump</p> <p><input type="checkbox"/> Pain or stiffness</p>	<p>Heart</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Heart attack/problems</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Chest pain or pressure</p> <p><input type="checkbox"/> Palpitation or fluttering</p> <p><input type="checkbox"/> Swollen ankles</p> <p>Lungs</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Chronic cough</p> <p>Breast</p> <p><input type="checkbox"/> Lump</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Pain</p>	<p>Intestinal</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Bowel problems</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Gallbladder problems</p> <p><input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> Nausea or vomiting</p> <p><input type="checkbox"/> Vomiting of blood</p> <p><input type="checkbox"/> Pain in abdomen</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Blood in stools</p> <p><input type="checkbox"/> Black, tarry stools</p> <p>Genital</p> <p><input type="checkbox"/> Testicular pain</p> <p><input type="checkbox"/> Urethral Discharge</p> <p><input type="checkbox"/> Chlamydia of gonorrhea</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> Difficulty in getting / maintaining erection</p> <p><input type="checkbox"/> Painful erection</p> <p><input type="checkbox"/> Premature ejaculation</p> <p><input type="checkbox"/> Sexual concerns</p>	<p>Urinary</p> <p><input type="checkbox"/> Kidney infections/stones</p> <p><input type="checkbox"/> Bladder infections</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Pain with urination</p> <p><input type="checkbox"/> Urine leakage</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Difficulty starting/stopping stream</p> <p>Extremities</p> <p><input type="checkbox"/> Arthritis, joint pain</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Broken bones</p> <p>Endocrine</p> <p><input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Osteoporosis</p>
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Any other illnesses, symptoms, 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 _____