

PLEASE READ THIS NOTICE PRIOR TO SIGNING

Dear Patient,

You are here today for an Annual Physical Exam. This is a preventive assessment and is billed as such. An Annual Physical Exam covers certain services that are determined by your insurance carrier. The following lists are provided as a guideline of covered preventive services, but are not guaranteed to be covered by your insurance carrier. You should contact your insurance carrier using the customer service number provided on the back of your insurance identification card to obtain a full list of preventive services covered by your insurance plan.

An Annual Physical Exam May Include:

- A review of your medical and family history
- Developing or updating a list of current providers and medications
- Height, weight, blood pressure, and other routine measurements
- A screening schedule (like a checklist) for appropriate preventive services
- Select laboratory tests (some test fees may be applied to your deductible or a coinsurance may be assessed based on your insurance plan)

An Annual Physical Exam does **NOT** include:

- Discussion of on-going or chronic conditions
- Medication refills
- Addressing acute conditions

As a courtesy, your provider may provide additional services during the scheduled time allotted for your Annual Physical Exam, **but there will be an additional office visit charge assessed.** If you would prefer your provider only perform services presumed to be covered under the Annual Physical Exam today you must inform the staff **PRIOR** to seeing your provider.

We will be happy to schedule additional appointments to cover any of your health concerns including follow ups for ongoing conditions, medication refills, and acute issues.

To learn more about Annual Physical Exams please contact your insurance carrier.

Date: _____

Patient Name Printed: _____

Patient Signature: _____

Capital Family Physicians, P.A.

2417 Atrium Drive, Suite 201
 Raleigh, North Carolina 27607
 Phone: (919) 232-0020
 Fax: 919-232-0030

Date: _____ Physician: _____

HEALTH HISTORY ASSESSMENT

Name: _____ Birth Date: _____

Address: _____

Allergies (Medicine, Food, Latex, etc.)/Reactions: _____

Current Medications (Include medications taken for sleep and as a laxative)

MEDICATION	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

Present/Previous Health Problems: (For family boxes, indicate for mother, father, sister, brother, children)

	Self	Family		Self	Family
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	Leg/Back/Neck Pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Mental Illness _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Blood Clots _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid _____	<input type="checkbox"/>	<input type="checkbox"/>			

List Surgeries/Hospitalizations with Dates: _____

List Previous and Current Conditions Being Treated for (ex. high blood pressure, diabetes): _____

Please list the dates of your last:

Mammogram _____	Tetanus Shot _____	Cholesterol Test _____
Flexible Sigmoid _____	Flu Shot _____	TB Skin Test _____
Chest X-ray _____	Pneumonia Shot _____	MMR _____
EKG _____	Hepatitis B Shot _____	

Have you ever had a blood transfusion? No Yes When: _____

HEALTH HISTORY ASSESSMENT (Cont.)

Do you have an advanced directive? Living Will Health Care Power of Attorney No

Do you wear: Glasses Contacts Hearing Aid

Use of Tobacco: No Stopped When _____

Cigarettes _____ Packs/day for # years _____ Pipe Cigar Chewing Tobacco Snuff

Use of Alcohol: No Occasionally Daily

Do you drink caffeine? Yes No

Where do you live? House Apartment Retirement Home Other _____

Do you live alone? Yes No With Family Other _____

Resources/support persons available to assist you: Spouse Other _____

Has there been a change in your marital status in the last year? No Yes _____

Has there been a death in your family in the last year? No Yes _____

Do you utilize: Cane Walker Wheelchair Crutches Artificial Limb

Do you need assistance with: Eating Walking Dressing Other _____

Have you had any problems with eating or drinking in recent weeks? No Yes

Problems with swallowing? No Yes Solids Liquids Pills

Unplanned weight gain/loss of 10 pounds or more in last 6 months or 5 pounds in one month? No Yes

Loss Gain _____ Pounds in _____ months

Do you have tooth or mouth problems that make it hard for you to eat? No Yes

Describe _____

Do you have: Dentures Bridges Caps Loose teeth

Do you eat fewer than 2 meals per day? No Yes

Are you on a special diet or supplement? No Yes

Do you exercise? No Yes Frequency _____ Type _____

Do you have trouble tolerating activity: No Yes Why? _____

Do you have any special requests due to your religious practices/culture/values? No Yes

Special Diet Blood Transfusion Other _____

Explain above _____

Religious Affiliation _____

Education: Last grade completed: _____

Present Occupation: _____

If retired, what was your previous employment? _____

How do you learn best? Reading TV/Video Demonstration Listening Doing

Do you have difficulty understanding and reading written materials? No Yes

Do you have a need for education about health or disease topics? No Yes Topic _____

Completed By: _____

Relationship to Patient: _____

SYSTEMS REVIEW

	YES	NO	COMMENTS
A. GENERAL			
1. Do you worry about your health?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Do you usually feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Do you feel that stress is adversely affecting your health?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. SKIN <i>Have you noticed:</i>			
1. Skin rashes or itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Growths on the skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Sores that do not heal	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Change in the color or size of moles	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. EYES <i>Have you noticed:</i>			
1. Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Draining or itching eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Pain in your eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Glaucoma check in the past year	<input type="checkbox"/>	<input type="checkbox"/>	_____
D. ENT <i>Have you had:</i>			
1. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Nasal stuffiness or drainage	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Frequent or severe nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Mouth sores that do not heal	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Recurrent sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
E. RESPIRATORY <i>Have you had:</i>			
1. Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. To sleep on more than one pillow # _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Waking up short of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. A constant cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Wheezing in your chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Exposure to tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Recurrent history of bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Recurrent history of pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
F. CARDIOVASCULAR <i>Have you had:</i>			
1. Pain/pressure in your chest, jaw, arm with exercise	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Palpitations of your heart at rest or during exercise	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. A previous heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Swelling in your ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Cramps/pain in legs with walking	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Changes in the color of your fingers or toes	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. History of high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. History of abnormal EKG	<input type="checkbox"/>	<input type="checkbox"/>	_____
G. MUSCULOSKELETAL <i>Have you had:</i>			
1. Pain in joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Swelling in joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Morning stiffness in joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Pain in joints in cold weather	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Pain in lower back which interferes with activities	<input type="checkbox"/>	<input type="checkbox"/>	_____

SYSTEMS REVIEW (Continued)

H. GASTROINTESTINAL <i>Have you had:</i>	YES	NO	COMMENTS
1. Any change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Any weight changes recently	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Abdominal or stomach pains	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Food intolerances (to fatty, greasy, spicy foods)	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Vomiting of blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Black or tarry stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Diarrhea in the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Constipation on regular basis	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Regular use of laxatives	<input type="checkbox"/>	<input type="checkbox"/>	_____

I. URINARY <i>Have you had:</i>			
1. Difficulty with urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Burning or pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Hesitation with urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Getting up at night to urinate more than one time	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Loss of urine with cough/sneeze	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Problems with sexual function	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. (Men) Prostate gland trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____

J. NERVOUS SYSTEM <i>Have you had:</i>			
1. Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Dizziness or light headedness	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Episodes of fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Difficulty remembering recent events	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Episodes of crying	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. An urge to commit suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Frequent feelings of agitation or loss of control	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Tingling or numbness arms/legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Trouble speaking	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Difficulty with balance, coordination or weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____

K. GYN (WOMEN ONLY) <i>Have you had:</i>			
1. Regular monthly periods (Date last period: _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Spotting/bleeding between your periods	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Heavy bleeding with your periods	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Pain or cramping with your periods	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Bloating/irritability before your period	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Use birth control (Form: _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Have you passed menopause	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when? _____
10. Monthly breast self-exam	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how long? _____

Number Pregnancies _____ Number Children Born Alive _____ Number Miscarriages _____

Number Stillborns _____ Number C-sections _____

Complications with pregnancy(s) _____