Patient Chart# _____

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 _____	☐	☐	Leg/Back/Neck Pain _____	☐	☐
Diabetes _____	☐	☐	Hiatal Hernia _____	☐	☐
Heart Problems _____	☐	☐	Convulsions/Seizures _____	☐	☐
Arthritis _____	☐	☐	Kidney Disease _____	☐	☐
Breathing Problems _____	☐	☐	Bleeding Problems _____	☐	☐
High Blood Pressure _____	☐	☐	Depression/Mental Illness _____	☐	☐
Cancer _____	☐	☐	HIV/AIDS _____	☐	☐
Hepatitis _____	☐	☐	Phlebitis/Blood Clots _____	☐	☐
Thyroid _____	☐	☐			

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?	☐	☐	
2. Do you usually feel tired?	☐	☐	
3. Do you feel that stress is adversely affecting your health?	☐	☐	
B. SKIN *Have you noticed:*			
1. Skin rashes or itching	☐	☐	
2. Growths on the skin	☐	☐	
3. Sores that do not heal	☐	☐	
4. Change in the color or size of moles	☐	☐	
C. EYES *Have you noticed:*			
1. Blurred vision	☐	☐	
2. Double vision	☐	☐	
3. Draining or itching eyes	☐	☐	
4. Pain in your eyes	☐	☐	
5. Glaucoma check in the past year	☐	☐	
D. ENT *Have you had:*			
1. Difficulty hearing	☐	☐	
2. Ringing in your ears	☐	☐	
3. Nasal stuffiness or drainage	☐	☐	
4. Frequent or severe nosebleeds	☐	☐	
5. Mouth sores that do not heal	☐	☐	
6. Recurrent sinus infections	☐	☐	
E. RESPIRATORY *Have you had:*			
1. Difficulty breathing	☐	☐	
2. To sleep on more than one pillow # _____	☐	☐	
3. Waking up short of breath	☐	☐	
4. A constant cough	☐	☐	
5. Coughing up blood	☐	☐	
6. Wheezing in your chest	☐	☐	
7. Exposure to tuberculosis	☐	☐	
8. Recurrent history of bronchitis	☐	☐	
9. Recurrent history of pneumonia	☐	☐	
F. CARDIOVASCULAR *Have you had:*			
1. Pain/pressure in your chest, jaw, arm with exercise	☐	☐	
2. Palpitations of your heart at rest or during exercise	☐	☐	
3. A previous heart murmur	☐	☐	
4. Swelling in your ankles	☐	☐	
5. Cramps/pain in legs with walking	☐	☐	
6. Changes in the color of your fingers or toes	☐	☐	
7. History of high blood pressure	☐	☐	
8. History of abnormal EKG	☐	☐	
G. MUSCULOSKELETAL *Have you had:*			
1. Pain in joints	☐	☐	
2. Swelling in joints	☐	☐	
3. Morning stiffness in joints	☐	☐	
4. Pain in joints in cold weather	☐	☐	
5. Pain in lower back which interferes with activities	☐	☐	

SYSTEMS REVIEW (Continued)

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

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

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

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

Number Pregnancies _____ Number Children Born Alive _____ Number Miscarriages _____

Number Stillborns _____ Number C-sections _____

Complications with pregnancy(s) _____

_____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching TV				
h. Moving or speaking so slowly that other people could have noticed, or the opposite; being so fidgety or restless that you have been moving around more than usual				
i. Thoughts that you would be better off dead or of hurting yourself in some way				

2. If you checked any off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Total Score _____