MULTICARE ASSOCIATES
MEDICAL CENTERS

ADULT PREVENTIVE PHYSICAL EXAM INSTRUCTIONS

You are scheduled to check in at _____ for your appointment with _____

on_____at_____AM/PM at our _____ location.

Your provider has given you an extended appointment time for your preventive exam.
*If you are unable to make your appointment, please call at least 24 hours in advance at **763-785-4500**.*
Thank you for your cooperation.

Enclosed are the adult preventive physical **forms** you will need to fill out. **Please complete and bring this packet with you to your appointment.** This information is extremely valuable for your provider to have when you check in for your appointment. **If you do not bring these completed forms with you, we may need to reschedule your appointment.** It is also very important for the provider to know all the medications and/or treatments you are taking. Therefore, please be sure to bring all your medications with you to your appointment.

What is included in your preventive exam (annual physical):

- Review your past medical, social, and family history
- Complete physical exam
- Discuss screening tests or services you may be due for
- Medication review
- Education/counseling on how to improve your health and prevent disease

What is not included in a preventive exam (annual physical):

- Monitoring a problem or condition you already have, including lab tests and medication refills
- Treatment of problems found during the preventive exam
- Treating an acute illness (cold, flu, bad cough, back pain, etc.)

If any of these types of services are provided, you may owe a copay.

Insurance companies require that preventive care and medical treatment be billed separately which means that if your insurance pays for preventive care at 100% ,but you are **treated for something in addition to the preventive exam and are billed an office visit, you may be charged a copay or it may be applied to your deductible**.

You can choose to schedule a separate appointment to address those concerns, or if time permits, you and the provider can address them at the time of your physical with the understanding there may be an additional office visit charge.

SEE REVERSE SIDE FOR MORE INFORMATION

FASTING INSTRUCTIONS

MORNING APPOINTMENTS ONLY: Do not take anything by mouth 12 hours prior to the exam. Please take your medications and drink plenty of water. Avoid all alcohol for at least 72 hours before your appointment.

AFTERNOON APPOINTMENT: Do not come in fasting. Your provider may have you return at a later date for an early morning lab appointment for lab work you may need. Be sure to take your medications.

Attention Patients who are 65 Years and Older

All preventive physical exams, for patients who are 65 years and older, now include Medicare's wellness visit components- also known as the Welcome to Medicare Exam (IPPE), Initial Wellness Visit (IWV) or Annual Wellness Visit (AWV). The Medicare Wellness portion of the visit is at **no cost to you.**

We look forward to seeing you. If you have any questions, please do not hesitate to contact the clinic.

763-785-4500

MULTICARE ASSOCIATES

Date of Appointment: _____ *Adult Female Preventative Physical Exam*

Name: _____ **Date of Birth:** _____ **Provider:** _____

PLEASE COMPLETE ALL PAGES

Medications-Please list all medications you are taking: Include dosage and frequency of each as well as vitamins, over-the-counter and herbal products:

_____

_____

Medication Allergies: _____ **Latex Allergy**: ○ Yes ○ No

Past Medical History (check any condition or disease you've had)

- ○ Allergies; **What type** _____
- ○ Anemia
- ○ Angina
- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Atrial fibrillation
- ○ Blood Clots: **Where**_____
- ○ Cancer: **Type** _____
- ○ Cardiac arrhythmia
- ○ COPD
- ○ Coronary (Heart) artery disease: **Type**_____
- ○ Depression
- ○ Diabetes- **What type**: 1, 2, gestational
- ○ Elevated Lipids (high cholesterol): **Type**_____
- ○ Gallbladder disease
- ○ GERD
- ○ Headache, migraine
- ○ Heart disease
- ○ Heart valve disorder
- ○ Hepatitis/liver disease
- ○ Hypertension
- ○ Irritable bowel disease
- ○ Myocardial Infarction (heart attack)
- ○ Osteoporosis
- ○ Renal (kidney) disease
- ○ Seizure disorder
- ○ Thyroid disease
- ○ Other: _____

IMPORTANT INFORMATION

As part of your physical, it is important that you inform the provider about any concerns and problems that you have. Please be aware, if during your physical exam, any of those concerns or problems require treatment (such as x-rays, tests, or you are given a prescription or advice) you may be charged for an office visit in addition to the physical charge.

Past Surgical History

	Year		Year		Year
Angioplasty	_____	Gastric bypass	_____	Breast augmentation (implants)	_____
Angio w/ stent	_____	Hernia repair	_____	Bilateral tubal ligation	_____
Appendix removed	_____	Hip replacement	_____	Breast biopsy	_____
Arthroscopy of knee	_____	Knee replacement	_____	Cesarean section	_____
Back surgery	_____	LASIK	_____	D and C	_____
Coronary artery bypass	_____	Liver biopsy	_____	Hysterectomy	_____
Carpal tunnel release	_____	Surgery for broken bones	_____	Mastectomy	_____
Cataract extraction	_____	Pacemaker	_____	Uterine fibroids removed	_____
Gallbladder removed	_____	Small bowel resection	_____	Breast reduction	_____
Colon resection	_____	Thyroid removed	_____	Ovaries & fallopian tubes removed	_____
Colostomy	_____	Tonsils removed	_____	Other: _____	_____

Have you ever had any of the following? Circle any that apply.

STD Exposure	PID	HPV	Cryotherapy
HIV	Genital Warts	Abnormal Pap Test	
Gonorrhea	Colposcopy	LEEP Procedure	
Herpes	Chlamydia	Cone biopsy	

Please list the year you had the following preventative services:

Pap smear	_____	Bone Density (DEXA)	_____	Colonoscopy	_____
Mammogram	_____	Tetanus Booster	_____	Cholesterol	_____

Family History: Please use the relationship abbreviations shown below to identify who in your family has the disease or health problem

M= Mother **F**= Father **S**= Sister **B**= Brother **MGM**= Maternal grandmother (your mother's mother) **MGF**= Grandfather (your mother's father)
PGM= Paternal grandmother (your father's mother) **PGF**= Paternal grandfather (your father's father)

	Relationship	What age	Cause of Death
☐ ADD/ADHD	_____	_____	☐
☐ Alcoholism	_____	_____	☐
☐ **Allergies***	_____	_____	☐
☐ Alzheimer's	_____	_____	☐
☐ **Arthritis***	_____	_____	☐
☐ Asthma	_____	_____	☐
☐ Blood disorder	_____	_____	☐
☐ **Cancer**-breast**	_____	_____	☐
☐ **Cancer**-cervical**	_____	_____	☐
☐ **Cancer-** Colon**	_____	_____	☐
☐ **Heart disease***	_____	_____	☐
☐ Depression	_____	_____	☐
☐ Developmental delay	_____	_____	☐
☐ **Diabetes***	_____	_____	☐
☐ Eczema	_____	_____	☐

	Relationship	What age	Cause of Death
High cholesterol*	_____	_____	☐
Genetic disease	_____	_____	☐
Hearing problems	_____	_____	☐
High blood pressure	_____	_____	☐
Irritable bowel disease	_____	_____	☐
Learning disability	_____	_____	☐
Mental illness	_____	_____	☐
Migraines	_____	_____	☐
Obesity	_____	_____	☐
Osteoporosis	_____	_____	☐
Peripheral vascular disease	_____	_____	☐
Renal/kidney disease	_____	_____	☐
Seizures	_____	_____	☐
Stroke	_____	_____	☐
Thyroid disorder	_____	_____	☐

If you have a history of **other types of cancer in your family, please list them below along with the family member's relationship to you:

_____

Pregnancy history---------- ◊ **Detail**

Enter the number of pregnancy events you've had for each:

Full Term	Premature	C-Section	Vaginal Deliveries	Live Births	Live at Present	Ectopic	Miscarriage	Abortion
____	____	____	_____	____	_____	____	____	____

Are you pregnant? O No O Yes O Possible O Not pertinent

Type of Birth Control: _____ Contemplating pregnancy? O No O Yes

Menses ----------

Last Menstrual Period _____

O regular O irregular O absent

Flow: O heavy O medium O light O painful

Frequency: [ ]

Breast

No	Yes		Side
O	O	Discharge	[ ]
O	O	Lumps	[ ]
O	O	Pain	[ ]
O	O	Do self exams?	

Postmenopausal----------

Age at menopause [ ]

No	Yes	
O	O	Hormone replacement therapy

Type [ ]

Years taken [ ]

Menopausal Symptoms--

☐ none

No	Yes	
O	O	Hot flashes
O	O	Insomnia
O	O	Night sweats
O	O	Vaginal Dryness

Additional Symptoms----------

☐ No significant symptoms

No	Yes		No	Yes	
O	O	Abnormal bleeding	O	O	Up at night to urinate
O	O	Anxiety	O	O	Sexual problems
O	O	Decreased libido	O	O	Sleeping problems
O	O	Depression	O	O	Leaking urine
O	O	Difficulty falling asleep	O	O	Urinary urgency
O	O	Painful sexual intercourse	O	O	Vaginal Discharge
O	O	History of infertility	O	O	Vaginal itch

◊ **OBGYN Confidential Information** ----------

Sexually active:	# of partners:	Do you practice safe sex?
O No	Current ____	O No
O Yes	Lifetime ____	O Yes
O Previously		O Sometimes

Orientation: O Opposite Sex O Same sex O Both

Would you like an STD test today O No O Yes

◊ **Depression Screening**

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

1. Little interest or pleasure in doing things O No O Yes
2. Feeling down, depressed or hopeless O No O Yes

◊ **Advanced Directives**

Living Will O No O Yes

Nutrition----------

Diet:

O Balanced Diet (meat, grains, fruits &vegetables)

O Vegetarian O Vegan O Low Carb (Atkins/South Beach) O High Fat

No	Yes	
O	O	Calcium Intake (food or vitamin) _____
O	O	Vitamin D Supplement

How many servings of dairy per day?_____

Social History----------

Exercise/Activity

Activity Level: O None O Light O Moderate O Vigorous

Exercise Frequency _____

***Marital Status** O Single O Married O Divorced O Life partner-same sex O Life partner-opposite sex O Other: _____

*Do you feel safe at home? O No O Yes

***Occupation** (even if you are now retired) _____

Tobacco/Alcohol

No	Yes	Former:	
O	O	O	Do you use tobacco or nicotine products?
O	O		Exposed to second hand smoke?
O	O	O	Drinks alcohol ◊ **Details**

Number of drinks: _____ Every: Day / Week /Month

Last drink: _____

***CAGE**

O No O Yes Have you ever felt like you should cut down your drinking?

O No O Yes Have you ever felt bad or guilty about your drinking?

Please mark any of the following symptoms you've had in the past 12 months <u>that are concerning to you</u>

Overall health ☐ All No

No	Yes	
○	○	Chills
○	○	Fatigue
○	○	Fever
○	○	Not feeling well
○	○	Night Sweats
○	○	Weight gain
○	○	Weight loss
○	○	Other:

_____

Head/Eyes/Ears/Nose/Throat
☐ All No

No	Yes	
○	○	Ear drainage
○	○	Ear pain
○	○	Eye discharge
○	○	Eye pain
○	○	Hearing loss
○	○	Nasal drainage
○	○	Sinus pressure
○	○	Sore throat
○	○	Visual changes
○	○	Other:

_____

Respiratory ☐ All No

No	Yes	
○	○	Chronic cough
○	○	Cough
○	○	Known TB exposure
○	○	Shortness of breath
○	○	Wheezing
○	○	Other:

_____

Cardiovascular ☐ All No

No	Yes	
○	○	Chest pain
○	○	Leg Pain
○	○	Feet swelling
○	○	Heart pounding
○	○	Other:

_____

Stomach/Intestinal
☐ All No

No	Yes	
○	○	Abdominal pain
○	○	Blood in stools
○	○	Change in stools
○	○	Constipation
○	○	Diarrhea
○	○	Heartburn
○	○	Loss of appetite
○	○	Nausea
○	○	Vomiting
○	○	Other:

_____

Genital/Urinary ☐ All No

No	Yes	
○	○	Painful urination
○	○	Blood in urine
○	○	High urine amount
○	○	Urinary frequency
○	○	Urinary incontinence
○	○	Urinary retention
○	○	Other:

_____

FEMALE Reproductive
☐ All No

No	Yes	
○	○	Abnormal pap
○	○	Painful periods
○	○	Painful intercourse
○	○	Hot flashes
○	○	Irregular periods
○	○	Vaginal discharge
○	○	Other:

_____

Metabolism/Endocrine
☐ All No

No	Yes	
○	○	Cold intolerance
○	○	Heat intolerance
○	○	Always thirsty
○	○	Always hungry
○	○	Other:

_____

Neurological ☐ All No

No	Yes	
○	○	Dizziness
○	○	Arm or leg numbness
○	○	Arm or leg weakness
○	○	Problems walking
○	○	Headache
○	○	Memory problems
○	○	Seizures
○	○	Tremors
○	○	Other:

_____

Mental Health ☐ All No

No	Yes	
○	○	Anxiety
○	○	Depression
○	○	Insomnia
○	○	Other

_____

Skin/Hair ☐ All No

No	Yes	
○	○	Brittle hair
○	○	Brittle nails
○	○	Hair loss
○	○	Excessive hair
○	○	Hives
○	○	Itching
○	○	Mole changes
○	○	Rash
○	○	Skin lesion
○	○	Other:

_____

Muscles/Bones ☐ All No

No	Yes	
○	○	Back pain
○	○	Joint pain: Knee, ankle, shoulder,
○	○	Joint swelling
○	○	Muscle weakness
○	○	Neck Pain
○	○	Other

_____

Hematologic (blood)/ Lymphatic ☐ All No

No	Yes	
○	○	Easy bleeding
○	○	Easy bruising
○	○	Large lymph nodes
○	○	Other:

_____

Immune System ☐ All No

No	Yes	
○	○	Contact allergies
○	○	Environmental allergies
○	○	Food allergies
○	○	Seasonal allergies
○	○	Other:

_____

IF YOU ARE <u>AGE 65 OR OLDER</u>, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you noticed any change in your ability to take care of yourself or do your usual activities? ☐ **Yes** ☐ **No**

Are your family members/friends expressing concern for your ability to take care of yourself? ☐ **Yes** ☐ **No**

Have you fallen in the past year? ☐ **Yes** ☐ **No** Do have any concerns about your memory? ☐ **Yes** ☐ **No**

Is there anything you can no longer do that you wish you still could? ☐ **Yes** ☐ **No** **What?** _____

Please check any of the activities you find difficult to do:

__ Walk a short distance (200 ft) __ Walk for 30 minutes __ Prepare meals __ Drive a vehicle

__ Shop for groceries or personal items __ Dress yourself __ Bathe yourself __ Clean your home