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 Male 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:

_____

_____

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 (irregular heart rate)
- ○ COPD
- ○ Coronary (heart) artery disease **Type**_____
- ○ Depression
- ○ Diabetes: ○ Type 1 OR ○ Type 2
- ○ 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	_____	Other: _____	_____
Angio w/ stent	_____	Hernia repair	_____		
Appendix removed	_____	Hip replacement	_____		
Arthroscopy of knee	_____	Knee replacement	_____		
Back surgery	_____	LASIK	_____		
Coronary artery bypass	_____	Liver biopsy	_____		
Carpal tunnel release	_____	Surgery for broken bones	_____		
Cataract extraction	_____	Pacemaker	_____		
Gallbladder removed	_____	Small bowel resection	_____		
Colon resection	_____	Thyroid removed	_____		
Colostomy	_____	Tonsils removed	_____		

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**-colon	_____	_____	☐
☐ **Cancer**-prostate	_____	_____	☐
☐ **Cancer-Other****	_____	_____	☐
☐ **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:

_____

Preventive Health History

Please enter the date you last had any of the following:

Cholesterol test	_____	Zostavax (shingles vaccine)	_____
Colonoscopy	_____	PSA (prostate cancer screening)	_____
Tetanus	_____	Pneumovax (pneumonia vaccine)	_____

◊ **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 ○ No ○ Yes
2. Feeling down, depressed or hopeless ○ No ○ Yes

◊ **Advanced Directives**

Do you have a Living Will ○ No ○ Yes

SOCIAL HISTORY Confidential Info.

Sexual Practices

Orientation: ○ Opposite sex ○ Same sex ○ Both
Sexually Active: ○ No ○ Yes ○ Previously
Condom Use: ○ No ○ Yes ○ Sometimes
Number of current partners: _____ *Number of life time partners: _____

Nutrition

Diet:
○Balanced Diet (meat, grains, fruits & vegetables every day)
○ Vegetarian ○ Vegan ○ Low Carb (Atkins/South Beach) ○ High Fat

Exercise / activity----------
Activity Level: ○ None ○ Light ○ Moderate ○ Vigorous
Frequency of exercise: ○ 2-3 times a week ○ 3-4 times a week ○ Daily ○ Never ○ Occasional

Tobacco/Alcohol

No Yes
○ ○ Do you use tobacco or nicotine products? If yes, how much _____
○ ○ Are you exposed to second hand smoke?

Drinks alcohol ○ No ○ Yes ○ Formerly Detail

Number of drinks: _____ Every: Day / Week / Month
When was your last drink: _____
If a former drinker, what year did you quit? _____

*CAGE

○ No ○ Yes Have you ever felt like you should cut down your drinking?
○ No ○ Yes Have you ever felt bad or guilty about your drinking?

Family Life----------

Marital Status**:** ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Life partner-same sex ○ Life partner-opposite sex

* Occupation**:** _____ **(**Even if you are now retired)

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

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

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	
○	○	Dribbling
○	○	Painful urination
○	○	Blood in urine
○	○	High urine output
○	○	Slow stream
○	○	Urinary frequency
○	○	Urinary incontinence
○	○	Urinary retention
○	○	Other:

MALE Reproductive ☐ All No

No	Yes	
○	○	Erectile Dysfunction
○	○	Penile Discharge
○	○	Sexual Dysfunction
○	○	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: