New Providence Internal Medicine Associates

Primary Care Partners
Affiliated with Atlantic Health System

COMPREHENSIVE PREVENTIVE CARE VISIT

Thank you for scheduling a routine Physical assessment. This is a perfect opportunity for us to work together to keep you healthy.

There is a lot of information about you that we need to gather and review. We probably have much of your medical history already, but it is best if you can review and confirm that we are completely up to date. This will let us use the time during our visit most effectively. You can share your information with us in 2 ways:

- Through MyChart (phone app or website). Complete all the information in the "e-check in" section, including the past history questionnaires. This will then go directly to your file in our electronic record.
- Or, answer all the questions on the sheets in this packet (even if you have completed similar forms in the past).

According to insurance carrier regulations the Physical does NOT include the diagnosis or treatment of new or ongoing problems. We can diagnose and treat new or ongoing problems at the time of your Physical, but your insurance may require us to apply a deductible or co-payment for that service. If you would prefer, we would be happy to schedule a separate visit to diagnose and treat additional problems and diagnoses.

We are honored that you have entrusted us with providing your medical care.

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If you are able to, please review your MyChart account, as many questions can be completed on-line.
If you are not able to access MyChart, then please complete the form below. Thank you.

(PREVENTIVE VISIT DOES <u>NOT</u> INCLUDE TREATMENT OF NEW OR ONGOING PROBLEMS)

Your name: _____ Date of physical: _____

Doctor you are seeing: _____ Date of birth: _____ Your age: _____

Please list all medications, supplements, vitamins, etc., and list all other doctors who are treating you. Fee l free to use additional sheets if needed

ALWAYS FILL THIS IN

Name	dosage	When do you take it	comments

Please list any other doctors who are currently treating you: _____

ONLY COMPLETE ANY SECTION BELOW WHICH HAS CHANGED SINCE YOUR LAST PHYSICAL:

1. Ongoing health problems: _____
2. Past health problems: _____
3. Past surgeries: _____
4. Hospitalizations, not for surgical problems: _____
5. Allergies to medications: _____
6. Family history: (list health problems, especially cardiovascular and cancers):

	Age (or year of birth) (if living)	Age when deceased	Health problems and conditions
Father			
mother			
sibling			
sibling			

7. Do you drink alcohol? If yes, how many drinks per week (one drink is 2 ounces of hard liquor, 5 ounces of wine, or 12 ounces of beer): _____
8. Do you currently smoke cigarettes: _____ if yes, how many packs per day? _____ At what age did you start smoking? _____ If you smoked in the past, at what age did you start? _____ At what age did you stop? _____ How many packs a day had you smoked? _____
9. Are you on a special diet (e.g. vegetarian, gluten free, etc.)? _____
10. Do you have a living will or advanced directive? _____
11. What type of regular exercise do you do? _____
12. What type of work do you do?_____ How many hours a week do you work? _____
13. What is your marital status: _____ How many children do you have? _____
14. Do you wear seatbelts when you drive or are a passenger?_____
15. Have you ever used intravenous drugs in the past? _____

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16. How would you describe your health overall?_____
17. Are you: heterosexual, homosexual, bisexual? (circle one)
18. How many hours of TV do watch a week?: _____

Please circle any symptoms which currently or significantly apply to you:

Headache	Men only:
Spinning of the room	• difficulty with erections
Weakness on one side of your body	• Loss of power of urinary stream
Numbness of hands or feet	Women only:
Black out or faint	• vaginal bleeding in between periods or after menopause
Shortness of breath	• Age at menopause: _____
Cough, Wheezing	Ongoing or severe back pain
Cough up blood	Difficulty with coordination
Pain or tightness in chest with exertion	Falls
Palpitations	Tremor
Pain in the stomach	Fatigue
Severe heartburn	Sleep:
Food sticks when you swallow	• How many hours do you sleep at night? ____
Loss of appetite	• Ever stop breathing during sleep?
Nausea, Vomiting	• Difficulty falling asleep or staying asleep
Unintentional weight loss	Swelling of the ankles
Blood in the stool	lightheadedness
Constipation	Memory loss
Diarrhea	**Date of Last General Screening:**
Black stool	Mammogram
Pain in joints	Pap test
Rash or lumps on your skin	Bone Density (DEXA)
History of skin cancer	Colonoscopy, Cologuard
Do you use sunblock?_____	Stool test for blood (hemoccult)
Difficulty with vision	**List the date of Last Immunizations:**
Last eye doctor visit: _____	Influenza (flu shot)
Painful urination	pneumonia
Blood in the urine	Tetanus/Adacel/Boostrix/dTAP
Loss of urine (incontinence)	Shingles/Shingrix
History of kidney stones	
How many times do you wake at night to urinate? ___	

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Feeling nervous, anxious, or on edge	0	1	2	3
4. Not being able to stop or control worrying	0	1	2	3

Any other questions or issues to discuss with the doctor?

Your Name: _____