PromptMD

FAMILY PRACTICE PHYSICAL EXAM HISTORY FORM

To provide you with better care our doctor would like to know you better.

<u>Please complete this form PRIOR to your visit</u> and preferably on the computer.

This should only take approximately 15 minutes, please plan accordingly, answer as accurately as possible, and help us to help you.

Below are general preventative measures that may or may NOT be applicable to you.

Please, try to answer the following questions, as they may be important for your and your family's health.

If something is not applicable put N/A or you do not know then LEAVE BLANK. THANK YOU!

Name: _____ Date of Birth____/____/_____ Sex: M F

Best Contact Number: _____ Email: _____

Initial Screening:

Have you traveled outside of the U.S. within the past 30 days? (If yes, Where?) _____

Have you had a FLU SHOT this season? (If yes, when?) _____

Have you fallen in the past 6 months? (60+, how many times have you fallen in the last year?) _____

Have you had a Colonoscopy/Date? _____

Have you had a Pap Smear/Date? _____

Have you had a Mammogram/Date? _____

Height: _____ Weight: _____

(Office Use) BMI: _____ BP: _____ Pulse: _____ Resp: _____ Temp: _____ O2: _____

(Office Use) Urinalysis: Leu: ____ Nit: ____ Uro: ____ Pro: ____ pH: ____ Blo: ____ SG: ____ Ket: ____ Bil: ____ Glu: ____

Social Screening:

Tobacco Use :_____(Daily/Weekly)

E-Cig Use :_____(Daily/Weekly)

Recreational Drug Use :_____(Daily/Weekly)

Alcohol Use :_____(Daily/Weekly)

Caffeine :_____(Daily/Weekly)

Exercise :_____(Daily/Weekly)

Last Menstrual Period: _____

Currently Pregnant: Y N (If yes, how many weeks?) _____

Medications (please list):

Taking currently: _____

Over the counter medications: _____

Past medications you used to take: _____

Folic acid / multivitamins? _____

Allergies (medications, foods, environment, etc.): _____

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Medical History/Concerns:

Any past medical history: _____

Family History? (High blood, diabetes, cancer, etc.)

_____

Past surgical history?

_____

When was your last Physical Exam?

_____

When was your last blood work?

_____

When was your last Dental exam?

_____

When was your last Ophthalmology (eye) exam?

_____

Any Specialist visits (cardiologist, pulmonologist, gastroenterologist, obgyn, etc.)

_____

Dexa Scan (for osteoporosis, Females 65+)

_____

Fecal occult Blood test (50+, every year)

_____

Endoscopy? _____

STD/HIV Testing? (Do you want to be tested today?)

_____

Abdominal Aortic Aneurism screening ultrasound? (65+ Males who EVER smoked 100 cigarettes or more)

_____

Low dose CAT Scan of the chest (yearly for 55-80 yo if current/past heavy smoker) _____

Obstructive sleep apnea concerns? (daytime sleepiness, morning headache, snoring?)

_____

Any large (5mm or more) moles or skin lesions that recently changed size, color, or stated to bleed?

_____

Home safety concerns? (Domestic violence? Physical, emotional, verbal abuse?) _____

What are your usual blood pressure numbers? _____

What are your sugar numbers? (Finger stick **– diabetic only**) _____

Are you a vegetarian/ Vegan? _____

Do you avoid certain food groups? Why? _____

What are your Healthy Habits? _____

What are your Unhealthy Habits? _____

Vaccines:

Zoster Vaccine (needed if you are 30+ and had actual chicken pox disease) _____

TDAP Vaccine (need every 7-10 years) _____

HPV Vaccine (11 yo-26 yo both F and M, 11-15 yo 2 doses 0-6 mo, 15-27 yo need 3 doses 0-2m-6m ,) _____

Pneumonia Vaccine PPSV23 (Two Doses 5 years apart: if 19+ yo and smoker, diabetic, heavy alcohol use or any chronic disease, diabetes, kidney disease) _____

Pneumonia Vaccine PCV 13 (anyone 65+ yo) _____

Meningitis Vaccine (teenagers- two doses at 11yo and 16 yo) _____

have you ever had a BCG Vaccine? _____

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	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. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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 a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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
☐	☐	☐	☐