Dear Patient:

To insure that your physical examination is of the highest quality and comfort, please observe the following:

**PHYSICAL EXAM NOTES**

Please bring the Physical Exam forms completely filled out with you on the day of your scheduled exam.

Use an ink pen to fill out the Physical Exam forms writing your name and the date on top of each page.

On the day of your examination:

- **PLEASE DO NOT USE BODY LOTIONS.**
- **PLEASE DO NOT USE PERFUME OR COLOGNE AFTER YOUR BATH.**
- **WEAR LOOSE FITTING CLOTHING.**
- **PLEASE DO NOT WEAR PANTYHOSE.**

It is advisable to leave small children at home so that the physician has your complete attention during the examination.

Please call the member services number on the back of your insurance card and ask if the physical examination will be covered and what tests may or may not be covered during the physical examination, i.e. blood work, EKG, chest x-ray, etc.

If you have not eaten or drank any liquid (except for sips of water) for at least 8 hrs on the day of your examination, your laboratory studies can be done on the same day. If you are unable to wait that long for a meal, then your laboratory studies can be scheduled for another day.

If you decided to go without food or drink until your visit, you may take your medications at the normal time with small sips of water.

There will be a $50 charge for any physical not cancelled within 24 hours prior to your appointment.

Thank you,

Staff at Jupiter Family Healthcare

[6/2017]
Important Information Regarding Your Physical

Jupiter Family Healthcare providers practice comprehensive medical care that is based on prevention as well as evaluation and management of your diseases, complaints and concerns.

Today you are scheduled for your **PHYSICAL EXAM**, often called an annual wellness exam, annual health maintenance exam or yearly check-up. According to insurance coding guidelines, this visit is designed to educate you on changes you can make to live a healthier life and to provide screening tests appropriate for your age and gender. It includes a review of your personal medical and social history, family medical history, counseling on immunizations, a review and discussion of your diet and exercise habits. It will also include the potential need for additional screenings based on age and personal history. Preventative services generally include the following:

-Immunizations
-Nutrition/ education review
-Medication review
-Preventative screenings: labs, mammograms, colonoscopy

Many insurance plans today now cover preventative services at 100%. This Physical Exam/ Wellness exam encounter is NOT designed to address specific complaints or to manage known medical conditions.

Today you may receive services that could be applied to your plans deductible, coinsurance or copay. **OFFICE VISITS** for new problems and/or management of an existing condition(s) are designated for the evaluation, management and treatment of single or multiple concerns or conditions. In some cases throughout the course of your exam, your provider may identify a new medical concern. If this occurs, your routine physical will expand to include an office visit and perhaps additional condition specific testing will be ordered. These additional service(s) are NOT considered part of your physical exam by your insurance company. If this occurs, you will be billed for your physical exam AND an office visit. Billing for both services is compliant with insurance billing guidelines. If your plan charges copays for the office visits, you will be asked for that co-payment by a member of our team. Examples include but are not limited to:

-Headaches
-Chest pain
-Arthritis

Hypertension
-Asthma
-Fatigue

Diabetes
-Joint pain
-Weight loss/ gain

Cough/ Cold/ Allergy
- GYN concerns
- Back/ Joint pain

Medication monitoring

Any Prescription or REFILL

It is important to understand your individual benefit coverage as benefits differ from plan to plan and in some cases from year to year. If you have questions, please contact your insurance company.

Your signature below indicates that you have read and understand that you will be financially responsible for the portion of the visit provided today that may not be covered in full by your insurance company.

____________________  ___________________  ___________________
Signature               Printed name              Date
JUPITER FAMILY HEALTHCARE

NAME_________________________________________  Date ___/___/___

REVIEW OF SYSTEMS:

1. GENERAL:
   Do you usually feel persistently tired or worn out?  Yes   No
   Have you recently been drinking more water or fluids?  Yes   No
   Has there been any unusual weight gain or loss recently?  Yes   No

2. CARDIOVASCULAR:
   Do you have pain, tightness or pressure in the front or back of your chest?  Yes   No
   Does your heart ever beat fast or irregularly?  Yes   No
   Do you have any swelling of your feet or ankles?  Yes   No
   Do you have cramps in the calf muscles when you walk?  Yes   No
   Do your fingers or toes ever get cold, become numb, or get very white or bluish?  Yes   No
   Have you ever been told you have a heart murmur?  Yes   No

3. CENTRAL NERVOUS SYSTEM:
   Do you have frequent or severe headaches?  Yes   No
   Do you often have spells of dizziness, faintness or lightheadedness?  Yes   No
   Have you recently fainted, blacked out, lost consciousness?  Yes   No

4. EYES:
   Have you had:
   Any pain in your eyes?  Yes   No
   blurry vision?  Yes   No
   change in vision?  Yes   No
   cataracts or implants?  Yes   No
   When did you last see an eye doctor?  ____________
   was the exam normal?  Yes   No

5. ENT:
   Do you have:
   any trouble hearing?  Yes   No
   ringing or buzzing in your ears?  Yes   No
   persistent hoarseness?  Yes   No
   Sinus trouble?  Yes   No
   Do you use a hearing aid?  Yes   No
   When did you last visit a dentist?  ____________

6. GASTROINTESTINAL:
   Have you recently noted any trouble swallowing?  Yes   No
   Do you have a lot of indigestion or heartburn?  Yes   No
   Have you ever vomited blood?  Yes   No
   Are you bothered by constipation?  Yes   No
   Do you have frequent loose stools or diarrhea?  Yes   No
   Have you recently had any change in the frequency of bowel movements?  Yes   No
   Do you have blood in your stool or black tarry stool?  Yes   No

7. SKIN:
   Do you have:
   any rashes or itching?  Yes   No
   any growths or lumps on your skin?  Yes   No
   any sores or wounds that do not heal?  Yes   No
   any change in the color or size of warts or moles?  Yes   No
   any change in your nails?  Yes   No
8. GENITOURINARY: Do you have:
   - burning or pain when you urinate? __ No __
   - to pass water frequently? __ No __
   - to get up at night to urinate? __ No __
   - How often? ______ times per night __ No __
   - trouble starting or stopping your urine? __ No __
   - trouble with losing urine when you cough or sneeze? __ No __
   - Have you ever passed blood in your urine? __ No __
   - Have you ever had an operation to prevent pregnancy? (Vasectomy or sterilization, such as a tubal ligation) __ No __

9. MUSCULOSKELETAL: Do you have:
   - a problem with back pain? __ No __
   - joint pain or stiffness (arthritis)? __ No __
   - trouble walking or using your hip, knee joints? __ No __
   - numbness or tingling in your arms or legs? __ No __

10. RESPIRATORY: Do you have:
    - a constant or bothersome cough? __ No __
    - coughing up blood? __ No __
    - difficulty breathing at rest or exercise? __ No __
    - a history of a positive reaction to a tuberculosis (TB) skin test? __ No __

11. PSYCHIATRIC: Do you have:
    - feelings of depression? __ No __
    - feelings of anxiety/nervousness/tensionness? __ No __
    - problems with your temper? __ No __
    - problems with memory? __ No __
    - have trouble sleeping? __ No __

12. ENDOCRINE: Do you have:
    - thyroid trouble? __ No __
    - heat or cold intolerance? __ No __
    - excessive sweating, thirst or hunger? __ No __

13. HEMATOLOGIC/ANEMIA:
    - Do you bruise or bleed easily? __ No __
    - Are you anemic? __ No __
    - Do you notice any lumps in your neck, armpits or groin? __ No __

14. MEN ONLY:
    - Do you have prostate gland trouble? __ No __
    - Have you had herpes? __ No __
    - Do you have any discharge or drip from your penis? __ No __
    - Do you know how to examine your testicles? __ No __
      If so, do you do this at least monthly? __ No __
**JUPITER FAMILY HEALTHCARE**

NAME__________________________________________ Date ___/___/___

14. **WOMEN ONLY:**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of last period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your last period normal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you passed the menopause or change?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, what year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of last Pap smear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your last Pap smear normal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of last mammogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your last mammogram normal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you have any pregnancies?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many?___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature____ Full Term_____ Abortions_____ Miscarriages_____</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you know how to examine your breasts? __ __ 
How often do you examine your breasts? __________

Do you have any:
- any lumps in your breasts? __ __ 
- discharge from your nipples? __ __ 
- vaginal drainage? __ __ 
- prolapse ("falling out") of the vagina or uterus? __ __ 
- any abnormal bleeding from the vagina in the past year? __ __ 

Have you had herpes? __ __
JUPITER FAMILY HEALTHCARE

NAME_________________________________________ Date ___/___/___

Tobacco Use Assessment and Cessation Intervention:
You currently smoke or chew tobacco or smoked in past 2 years Yes  No
If Yes
Do you have any desire to quit? Yes  No
Do you wish assistance on quitting? Yes  No

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)
Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than 1/2 the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

add columns:
TOTAL SCORE

minimal 1-4  mod-severe 15-19
mild 5-9 severe 20-27
moderate 10-14
ONLY ANSWER IF YOU ARE ON MEDICARE:
Medicare Wellness Exam Questionnaire ***(only for Medicare patients)***
Based on Medicare requirements, please answer the questions to the best of your ability. These are a requirement of the Medicare Wellness Program.

**Advanced Directives: (99497/99498)**
- Do you have a living will: Yes No
- Do you have a Health Care Proxy: Yes No
- Do you have a Power of Attorney: Yes No
- Patient has a Do Not Resuscitate Document: Yes No

**For JFH staff:**
- Copy of DNR on chart: Yes No
- Patient counseled at this visit: Yes No

**Activities of Daily Living:**
- Are you Independent: (If yes, skip to next section Fall Risk) Yes No
- Patient needs full help with all daily activities: Yes No

**If No, Patient needs help with the following:**
- Dressing: Yes No
- Grooming: Yes No
- Shopping: Yes No
- Bathing: Yes No
- Housework: Yes No
- Feeding: Yes No
- Toilet Use: Yes No
- Preparing Meals: Yes No

**Fall Risk Assessment:**
- Have you fallen 2 or more times in the last 12 month or have you fallen with injury in the past 12 months: Yes No

**If Yes:**
- Do you have a walker/cane or other ambulatory assistance: Yes No
- Have you seen a Specialist or Physical Therapy: Yes No

**AUDIT-C (Alcohol Use Disorders Identification Test) (M>=4, F>=3)**
1. How often did you have a drink containing alcohol in the past year?
   - (0) Never
   - (1) Monthly or less
   - (2) 2 to 4 times a month
   - (3) 2 to 3 times a week
   - (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when drinking?
   - (0) 1 or 2
   - (1) 3 or 4
   - (2) 5 or 6
   - (3) 7, 8, or 9
   - (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily