Jupiter Family Healthcare
www.jupiterfamilyhealthcare.com

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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

[2/18]

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	-Health habits
-Nutrition/ education review	-Sleep patterns
-Medication review	-STDs
-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	Hypertension	Diabetes	Cough/ Cold/ Allergy
-Chest pain	Asthma	Joint pain	GYN concerns
-Arthritis	Fatigue	Weight loss/ gain	Back/ Joint pain
-Abnormal labs	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:

	Yes	**No**
1. GENERAL:		
Do you usually feel persistently tired or worn out?	___	___
Have you recently been drinking more water or fluids?	___	___
Has there been any unusual weight gain or loss recently?	___	___
2. CARDIOVASCULAR:		
Do you have pain, tightness or pressure in the front or back of your chest?	___	___
Does your heart ever beat fast or irregularly?	___	___
Do you have any swelling of your feet or ankles?	___	___
Do you have cramps in the calf muscles when you walk?	___	___
Do your fingers or toes ever get cold, become numb, or get very white or bluish?	___	___
Have you ever been told you have a heart murmur?	___	___
3. CENTRAL NERVOUS SYSTEM:		
Do you have frequent or severe headaches?	___	___
Do you often have spells of dizziness, faintness or lightheadedness?	___	___
Have you recently fainted, blacked out, lost consciousness?	___	___
4. EYES: Have you had:		
Any pain in your eyes?	___	___
blurry vision?	___	___
change in vision?	___	___
cataracts or implants?	___	___
When did you last see an eye doctor?	_____	
was the exam normal?	___	___
5. ENT: Do you have:		
any trouble hearing?	___	___
ringing or buzzing in your ears?	___	___
persistent hoarseness?	___	___
Sinus trouble?	___	___
Do you use a hearing aid?	___	___
When did you last visit a dentist?	_____	
6. GASTROINTESTINAL:		
Have you recently noted any trouble swallowing?	___	___
Do you have a lot of indigestion or heartburn?	___	___
Have you ever vomited blood?	___	___
Are you bothered by constipation?	___	___
Do you have frequent loose stools or diarrhea?	___	___
Have you recently had any change in the frequency of bowel movements?	___	___
Do you have blood in your stool or black tarry stool?	___	___
7. SKIN: Do you have:		
any rashes or itching?	___	___
any growths or lumps on your skin?	___	___
any sores or wounds that do not heal?	___	___
any change in the color or size of warts or moles?	___	___
any change in your nails?	___	___

JUPITER FAMILY HEALTHCARE

NAME_____ **Date** ___/___/___

	Yes	**No**
8. GENITOURINARY: Do you have:		
burning or pain when you urinate?	___	___
to pass water frequently?	___	___
to get up at night to urinate?	___	___
How often?_____times per night	_____	
trouble starting or stopping your urine?	___	___
trouble with losing urine when you cough or sneeze?	___	___
Have you ever passed blood in your urine?	___	___
Have you ever had an operation to prevent pregnancy? (Vasectomy or sterilization, such as a tubal ligation)	___	___
9. MUSCULOSKELETAL: Do you have:		
a problem with back pain?	___	___
joint pain or stiffness (arthritis)?	___	___
trouble walking or using your hip, knee joints?	___	___
numbness or tingling in your arms or legs?	___	___
10. RESPIRATORY: Do you have:		
a constant or bothersome cough?	___	___
coughing up blood?	___	___
difficulty breathing at rest or exercise?	___	___
a history of a positive reaction to a tuberculosis (TB) skin test?	___	___
11. PSYCHIATRIC: Do you have:		
feelings of depression?	___	___
feelings of anxiety/nervousness/tenseness?	___	___
problems with your temper?	___	___
problems with memory?	___	___
have trouble sleeping?	___	___
12. ENDOCRINE: Do you have:		
thyroid trouble?	___	___
heat or cold intolerance?	___	___
excessive sweating, thirst or hunger?	___	___
13. HEMATOLOGIC/ANEMIA:		
Do you bruise or bleed easily?	___	___
Are you anemic?	___	___
Do you notice any lumps in your neck, armpits or groin?	___	___
14. MEN ONLY:		
Do you have prostate gland trouble?	___	___
Have you had herpes?	___	___
Do you have any discharge or drip from your penis?	___	___
Do you know how to examine your testicles?	___	___
If so, do you do this at least monthly?	___	___

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NAME_____ Date ___/___/___

14. WOMEN ONLY:	**Yes**	**No**
Date of last period _____		
Was your last period normal?	___	___
Have you passed the menopause or change?	___	___
If so, what year? _____		
Date of last Pap smear _____		
Was your last Pap smear normal?	___	___
Date of last mammogram _____		
Was your last mammogram normal?	___	___
Did you have any pregnancies?	___	___
How many?____		
Premature_____ Full Term_____ Abortions_____ Miscarriages_____		
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)

	Not at all	Several days	More than 1/2 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
			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.

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