

FENTON FAMILY MEDICINE

Patient History Form

Patient's Name: _____ Date of Birth: _____

Address: _____ Language: _____ Ethnicity: _____

E-mail Address: _____ I would like to access my Medical Records online: ☐ Yes ☐ No

Do you have an Advanced Directive? ☐ Yes ☐ No What pharmacy do you use? _____

Allergies

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No known drug allergies

If yes, please list: _____

Medications

Are you currently taking medications? If yes, please list medications below. ☐ No Reported Medications

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Problems

What is the reason for your visit today? _____

_____ ☐ No active problems

Which of the following conditions are you currently being treated or have been treated for in the past (please check):

- | | | | |
|--|--|--|---|
| ☐ Heart disease / Murmur / Angina | ☐ Shortness of breath | ☐ Eye disorder / Glaucoma | ☐ Diabetes |
| ☐ High cholesterol | ☐ Asthma | ☐ Seizures | ☐ Kidney / Bladder problems |
| ☐ High blood pressure | ☐ Lung problems / cough | ☐ Stroke | ☐ Liver problems / Hepatitis |
| ☐ Low blood pressure | ☐ Sinus problems | ☐ Headaches / Migraines | ☐ Arthritis |
| ☐ Heartburn (reflux) | ☐ Seasonal allergies | ☐ Neurological problems | ☐ Cancer |
| ☐ Anemia or blood problems | ☐ Tonsillitis | ☐ Depression / Anxiety | ☐ Ulcers / Colitis |
| ☐ Swollen ankles | ☐ Ear problems | ☐ Psychiatric care | ☐ Thyroid problems |

Other problems not listed above: _____

Please turn this sheet over to complete and sign this form

Patient History Form

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

How many packs per day? _____

If no, have you in the past? ☐ Yes ☐ No

When did you quit smoking? _____

How many years have you smoked? _____

Do you drink alcohol, beer or wine? ☐ Yes ☐ No

How many drinks per week? _____

If no, have you in the past? ☐ Yes ☐ No

Do you currently drink coffee and/or tea? ☐ Yes ☐ No

If yes, how many cups per day? _____

Do you exercise daily/weekly? ☐ Yes ☐ No

If yes, how many times per week? _____

Do you use seatbelts while driving? ☐ Yes ☐ No

Do you wear a helmet while riding a bike? ☐ Yes ☐ No

Family History

	Self	Father	Mother	Brothers	Sisters	Uncles	Aunts	Sons	Daughters
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									

Immunization History

Last Tetanus Vaccine (Tdap) _____ Influenza Vaccine _____ Pneumonia Vaccine _____

Last Tuberculosis (TB) Screening: _____ Result of TB screening: ☐ Positive ☐ Negative

If positive TB screen, date of last chest x-ray: _____ Result of chest x-ray: ☐ Positive ☐ Negative

Surgical History

List of surgeries and dates: _____

Date of last Colonoscopy: _____ Colonoscopy Results: _____

Female Gynecological History

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? ☐ Yes ☐ No Diagnosis: _____ Follow Up: _____

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis: _____

Date of last mammogram: _____ Last menstrual period: _____ Mammogram results: _____

Have you ever had a breast biopsy? ☐ Yes ☐ No Biopsy results: _____

By signing below, I hereby certify that, to the best of my knowledge, all information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ **Date** _____

Patient Name: _____

Date: _____

Yearly Physical Screening Form

Social History

Marital Status:

☐ Married	☐ Widowed	☐ Divorced	☐ Separated	☐ Unmarried
----------------------------------	----------------------------------	-----------------------------------	------------------------------------	------------------------------------

Work Status:

☐ Full-Time	☐ Part-Time	☐ Unemployed	☐ On Disability	☐ Retired
Occupation (current/previous):				

Tobacco use:

☐ Never Smoked Cigarettes	☐ Current Cigarette Smoker	☐ Former Cigarette Smoker
Year Started: Quit:	Avg. Packs Per Day:	☐ Vape Use

Dental, Vision, Hearing:

☐ Dental Problems	☐ Worsening Vision	☐ Hearing Difficulties
Dental Visits/Year: 0 1 2 3+	☐ Yearly Eye Doctor Visits	☐ Wear Hearing Aids

Nutrition (Avg. Servings per Day [on a normal week]):

Fruits:	Whole Grains:	Other Snacks:	Sugar Soda/Energy/Sports (fl oz):
Veg:	Other Grains:	Juice (fl oz):	Diet Soda/Energy/Sports (fl oz):
Protein foods:	Sugar Snacks:	Coffee/Tea (fl oz.):	Water (fl oz):

Exercise:

☐ Casual Walking	☐ Cycling	☐ Strength Training	☐ Yoga/Pilates
☐ Brisk Walking/Jogging	☐ Water Sports	☐ Calisthenics	☐ Aerobics
☐ Running	☐ Tennis/Pickleball	☐ Golf	☐ Other:
Times/Week:		Time/Session (minutes):	

Sleep:

Hours/Night:	☐ Snore loudly	☐ Worried I might have Sleep Apnea
☐ Difficulty Falling Asleep	☐ Daytime tired, fatigued, or sleepiness	☐ Diagnosed with Sleep Apnea
☐ Difficulty Staying Asleep	☐ Told I stop breathing during sleep	☐ Wear CPAP/BiPAP

Alcohol Use:

Drinks/Day:	Drinks/Month:	☐ No Use	☐ Rare Use (a few drinks/year)
☐ Think I drink too much	☐ Quitting on own	☐ Want Treatment	☐ History of Heavy Use

Patient Initials: _____

Drug Use:

☐ Never	☐ Former	☐ Current Occasional	☐ Current Frequent
--------------------------------	---------------------------------	---	---

Drug Type:

☐ Marijuana/THC (not CBD)	☐ Cocaine	☐ Methamphetamines
☐ Oral Opioid/Narcotic (non-prescribed)	☐ IV Opioid/Narcotic	☐ Hallucinogens
☐ Sedatives	☐ Other:	

Drug Treatment Readiness:

☐ Ready	☐ Not Ready	☐ I'm thinking about it
☐ Quitting on own	☐ Want Resources	☐ Want Treatment

Sexual History:

Sexual Partners (over last year):	☐ Condom Use	☐ Low libido
☐ Suspect STD Exposure	☐ Contraception Use	☐ Erection Difficulties/Quality Issues
☐ Request STD Testing	☐ Tubal ligation/Vasectomy	☐ Vaginal Dryness/Pain

Pap/Cervical Cancer Screening History:

Date Last Pap:	☐ Normal	☐ Abnormal	☐ Total hysterectomy (no cervix)
☐ Screening with PCP	☐ with OBGYN	Provider Name/Office:	

Colon Cancer Screening History:

Date Colonoscopy:	☐ Normal ☐ Abnormal (polyps, etc)	Location/Doctor:
Date Cologuard:	☐ Family History Colon Cancer	☐ Personal History Colon Cancer

Risk Assessment

Safety Elements:

☐ Wear Seat Belt	☐ Wear Sunscreen SPF 30+ in Sun	☐ Fall Protection/Bathroom Grab Bars
☐ No Texting and Driving	☐ Smoke/CO Detectors in House	☐ Helmet with Bicycle/Motorcycle

Personal History of:

☐ Elevated Cholesterol	☐ Prediabetes/Insulin Resistance	☐ Colon Polyps
☐ Heart Disease	☐ Diabetes	☐ Crohn's/Ulcerative Colitis
☐ Cancer (type):		

Family History (Please State Relationship):

☐ Heart Disease:	☐ Colon Cancer:	☐ Prostate Cancer:
☐ Diabetes:	☐ Breast Cancer:	☐ Other Cancer:

No Further Questions. Thank you for completing this paperwork!

REVIEW OF SYSTEMS

Please check or draw line through Yes or No for ALL below

Constitutional

- | Yes | No |
|--------------------------|---|
| ☐ | ☐ Excessive daytime sleepiness |
| ☐ | ☐ Fatigue |
| ☐ | ☐ Fevers |
| ☐ | ☐ Night Sweats |
| ☐ | ☐ Unexplained weight loss |
| ☐ | ☐ Easy bruising or bleeding |
| ☐ | ☐ Swollen glands |

Eyes

- | Yes | No |
|--------------------------|--|
| ☐ | ☐ New vision problems |
| ☐ | ☐ Eye discharge |
| ☐ | ☐ Eye pain |

Ears, Nose, Mouth, and Throat

- | Yes | No |
|--------------------------|--|
| ☐ | ☐ Loss of sense of smell |
| ☐ | ☐ New Hearing loss |
| ☐ | ☐ Frequent Nose bleeds |
| ☐ | ☐ Swallowing difficulties |

Head and Face

- | Yes | No |
|--------------------------|---|
| ☐ | ☐ Sinus pain |
| ☐ | ☐ Facial spasms or twitching |

Respiratory

- | Yes | No |
|--------------------------|--|
| ☐ | ☐ Cough |
| ☐ | ☐ Wheezing |
| ☐ | ☐ Shortness of breath |
| ☐ | ☐ Loud Snoring |
| ☐ | ☐ Insomnia |

Cardiovascular

- | Yes | No |
|--------------------------|---|
| ☐ | ☐ Chest pain |
| ☐ | ☐ Chest pressure |
| ☐ | ☐ Heart Palpitations |
| ☐ | ☐ Leg swelling |

Gastrointestinal

- | Yes | No |
|--------------------------|--|
| ☐ | ☐ Abdominal pain |
| ☐ | ☐ Constipation |
| ☐ | ☐ Diarrhea |
| ☐ | ☐ Frequent Heartburn |
| ☐ | ☐ Nausea |
| ☐ | ☐ Vomiting |
| ☐ | ☐ Red blood in stools |
| ☐ | ☐ Black or tarry stools |
| ☐ | ☐ Hemorrhoids |

Bladder & Sexual Function (Genitourinary)

- | Yes | No |
|--------------------------|--|
| ☐ | ☐ Discomfort and burning |
| ☐ | ☐ Loss of bladder control |
| ☐ | ☐ Loss of desire for sex |
| ☐ | ☐ Menopause (women) |
| ☐ | ☐ Trouble with erection (men) |
| ☐ | ☐ Urgency to urinate |
| ☐ | ☐ Urinating more than twice per night |
| ☐ | ☐ Change in urine stream |

Musculoskeletal

- | Yes | No |
|--------------------------|---|
| ☐ | ☐ Muscle pain or cramps |
| ☐ | ☐ Muscle weakness |
| ☐ | ☐ Restricted range of motion |
| ☐ | ☐ Joint pain |
| ☐ | ☐ Joint swelling |

Neurological

- | Yes | No |
|--------------------------|---|
| ☐ | ☐ Confusion |
| ☐ | ☐ Chronic Headaches |
| ☐ | ☐ New Onset Headaches |
| ☐ | ☐ Involuntary movements or jerking |
| ☐ | ☐ Lightheaded or dizzy |
| ☐ | ☐ Loss of consciousness/fainting/passing out |
| ☐ | ☐ Numbness or Tingling |
| ☐ | ☐ Seizure or convulsion |
| ☐ | ☐ Spinning or vertigo |
| ☐ | ☐ Tremor |
| ☐ | ☐ Trouble speaking |
| ☐ | ☐ Trouble walking |
| ☐ | ☐ Muscle Weakness |

Skin

- | Yes | No |
|--------------------------|---|
| ☐ | ☐ Rash |
| ☐ | ☐ Change in Mole/Abnormal Mole |
| ☐ | ☐ Non-healing sore |

Memory, Thinking, Mood, Psychiatric

- | Yes | No |
|--------------------------|--|
| ☐ | ☐ Suicidal |
| ☐ | ☐ Anxiety |
| ☐ | ☐ Depressed mood |
| ☐ | ☐ Hallucinations (seeing or hearing things) |
| ☐ | ☐ Suffering from domestic violence |

Endocrine

- | Yes | No |
|--------------------------|---|
| ☐ | ☐ Heat or cold intolerance |
| ☐ | ☐ Increased thirst |
| ☐ | ☐ Hot flashes |
| ☐ | ☐ Change of voice |

Annual Physical & Wellness Exam: What to Expect

Dear Valued Patient,

To help you get the most out of your annual physical or wellness exam, please review the information below about what is included in your visit and what may require a separate appointment or added billing.

What IS Covered in Your Annual Physical or Wellness Exam per Insurance Rules

- Vital Signs: Blood pressure, heart rate, respiratory rate, temperature, and weight.
- Physical Examination: Head-to-toe exam to check your overall health for commercial or Medicaid plans. This is not allowed within a straight Annual Medicare Wellness exam as it is a “no touch” visit. However, if you have Medicare along with an additional plan, a physical exam can be performed in most instances.
- Preventive Screenings: Recommendations for age-appropriate screenings (such screening blood tests, cancer screenings, and immunizations).
- Lifestyle Counseling: Guidance on nutrition, exercise, tobacco/alcohol use, and other healthy habits.
- Chronic Disease Risk Assessment: Screening for conditions like incontinence, fall-risk, osteoporosis, cognitive decline, and mental health problems, like anxiety and depression.

What is NOT Covered in an Annual Physical or Wellness Exam

Annual physicals and wellness exams are focused on prevention and general health maintenance. The following are not included and may require a separate visit:

- New or Ongoing Medical Problem Management: Evaluation or treatment of new symptoms (e.g., pain, rash, cough, fatigue, dizziness) or management of chronic conditions, if further assessment is made, including decision to continue or stop current medications.
- Medication Changes: Discussion of problems with current medications that require changes, adjustments, or new prescriptions.
- Procedures: Treatment of warts, precancerous skin lesions, joint injections, ear cleaning, or other in-office procedures.
- Detailed Mental Health Evaluation: In-depth assessment or management of mental health concerns based on positive screening questionnaires.
- Work, School, or Sports Forms: Completion of forms from entities outside our office.
- Specialist Referrals for New Issues: Referrals for new or complex problems.

We may need to schedule a separate appointment to address issues thoroughly. In some cases, we are however, able to address additional health concerns during your annual visit, which can help save you the time and inconvenience of scheduling a separate appointment. Please be aware, in order to comply with legal insurance billing requirements, an appropriate office visit charge must be billed to your insurance for the services provided on that day. This may result in an additional copay or fees, depending on your insurance plan.

For Medicare patients, please note that your annual wellness visit may need to be scheduled on a separate day, which can often be completed virtually for your convenience.

To Summarize

Insurance coverage for annual physicals and wellness exams is often limited to preventive care. Addressing other concerns during this visit may result in additional charges or copays.

If you have any further questions on these matters, please do not hesitate to discuss this matter with our office prior to your visit.

Kind Regards,
Jason Streff, DO, DABOM
Family Medicine, Obesity Medicine