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
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heartburn (reflux)
- ☐ Anemia or blood problems
- ☐ Swollen ankles
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Lung problems / cough
- ☐ Sinus problems
- ☐ Seasonal allergies
- ☐ Tonsillitis
- ☐ Ear problems
- ☐ Eye disorder / Glaucoma
- ☐ Seizures
- ☐ Stroke
- ☐ Headaches / Migraines
- ☐ Neurological problems
- ☐ Depression / Anxiety
- ☐ Psychiatric care
- ☐ Diabetes
- ☐ Kidney / Bladder problems
- ☐ Liver problems / Hepatitis
- ☐ Arthritis
- ☐ Cancer
- ☐ Ulcers / Colitis
- ☐ 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 If no, have you in the past? ☐ Yes ☐ No

How many packs per day? _____ When did you quit smoking? _____

How many years have you smoked? _____

Do you drink alcohol, beer or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many drinks per week? _____

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** _____

Today's Date:

PATIENT INFORMATION

Name: **Date of Birth:** **Age:**

Gender: **Race:** **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

SOCIAL HISTORY

Tobacco: ☐ Never ☐ Current ☐ Former; *Quit Date:*_____ Type: ☐ Smoke ☐ Chew

Alcohol: ☐ Never ☐ Occasional; *# of drinks per month:* ____ ☐ Daily; *# of drinks per day:* ____

Are you sexually active? ☐ Yes ☐ No

Current Diet: ☐ Well Balanced ☐ Low Fat ☐ Low Carb ☐ Low Salt ☐ Limited Junk Food ☐ Unhealthy

Do you Exercise? ☐ Yes ☐ No **Type of Exercise:** **Frequency:**

Home Environment: ☐ Private Home ☐ Assisted Living ☐ Other *(Describe)*:

FUNCTIONAL ABILITY & LEVEL OF SAFETY

Hearing Difficulty? ☐ Yes ☐ No **If yes, the difficulty is:** ☐ Slight ☐ Significant **Which ear(s):** ☐Right ☐ Left

Hearing Aids? ☐ Yes ☐ No **If yes, which ear(s):** ☐Right ☐ Left

Problems with Teeth or Dentures? ☐ Yes ☐ No **Do you always fasten your car seat belt?** ☐ Yes ☐ No

Do you Need Help with the following? *Check all that apply*

☐ Using the phone	☐ Preparing meals	☐ Managing medications	☐ Toileting
☐ Bathing	☐ Grooming	☐ Dressing	☐ Transportation
☐ Housework	☐ Managing money	☐ Shopping	☐ Laundry

Do you have any of the following home safety factors? *Check all that apply*

☐ Unfamiliar surroundings	☐ Uneven floors	☐ Handrails on the stairs
☐ Loose rugs	☐ Household clutter	☐ Poor household lighting
☐ Grab bars in the bathroom		

Do you have any of the following fall risks? *Check all that apply*

☐ Unsteady when walking	☐ Fallen in the past year	☐ Fear of falling
☐ Trouble with balance	☐ Taking multiple medications	☐ Sedative medication use
☐ Antidepressant medication use	☐ Blood pressure medication use	☐ Alcohol Use
☐ Loss of muscle tone/weakness	☐ Vision impairment	☐ Cognitive Impairment
☐ Mobility Impairment	☐ Blood pressure drop with position change	☐ Urinary incontinence

QUALITY OF LIFE

Has your physical/emotional health limited your activities with family/friends? ☐ No ☐ Sometimes ☐ Often ☐ Always

Rate your satisfaction with your social activities/relationships: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you always have enough money to buy the things you need to live such as food, clothes, housing? ☐ Yes ☐ No

Has someone been available to help you or be with you if you wanted? ☐ No ☐ Sometimes ☐ Often ☐ Always

How much pain have you had in general? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Have you been experiencing fatigue (tiredness, low energy) ☐ Yes ☐ No

Rate your health in general: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Rate your quality of life: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Rate your satisfaction with your life: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have concerns with the following: ☐ Feeling stressed ☐ Feeling angry ☐ Money/finances

OPIOID RISK SCREENING

Check all that apply

Family history of substance abuse: ☐ Alcohol ☐ Illegal drugs ☐ Prescription drugs

Personal history of substance abuse: ☐ Alcohol ☐ Illegal drugs ☐ Prescription drugs

Psychological Disease: ☐ ADD ☐ OCD ☐ Bipolar ☐ Schizophrenia ☐ Depression

Please continue on next page...

Patient Name: _____ DOB: _____

ADVANCE DIRECTIVES & END OF LIFE PLANNING	
Do you have the following?	
Living Will:	☐ Yes ☐ No
Durable Power of Attorney:	☐ Yes ☐ No
Advance Directive:	☐ Yes ☐ No
Have you reviewed your end of life decisions with your healthcare provider?	☐ Yes ☐ No
Did your healthcare provider agree with you on your end of life decisions?	☐ Yes ☐ No

Patient Signature: _____ Date: _____

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