		For Offi	ce Use Only: 🗌 Complet	e Physical  Other
Name	DOB	A	ngeToday's Da	ate
Preferred Name			·	
Past Medical History				
Current Medications & Do				
Medication	Dosage		Medication	Dosage
\\/\ \cdot\ \cdo		£+:	2 - ما د ما د ما	
What medications are you aller	gic to and what kind c	n reaction	i did you nave?	
Do you take herbs or supplements? Yes No	Which ones?			
List all diseases you have or have had in the past:				
☐ High Blood Pressure ☐ Elevated Choleste	erol 🗆 Cancer 🗆 Diabetes 🗆	☐Thyroid Disea	se Heart Disease	
Others				
Harmital Administrations (Com	overtee / Doeses down / Dis			
Hospital Admissions / Sur	geries / Procedures / Bio	Year		
icai		icai		
+		+		
Family History				
Father: Living - Illness	Moi	ther: 🗆 Livi	ng - Illness	
Deceased - Cause of death		□Dec	eased - Cause of death	
	esta which valativa and annusvinceta		•	
Has any parent, brother or sister had: (Please india) (A.) $\square$ Colon Cancer $\square$ Ovarian Ca			is) before age 55 if male, or age 65 if	female)
Colon Polyps Prostate Ca			one thinning)	
(B.) Stroke Diabetes	$\square$ Bleeding Disorders $\square$	Alcoholism		
☐ Glaucoma ☐ Kidney Dise	ease Arthritis 🗆	Depression		
Cosial History				
Social History Occupation	Married	Single =	Divorced Widowed Don	nestic Partner # of Children
Alcohol: drinks per week			widowed E-bon	restreatment " or enhancing
Have you ever had problems with alcohol use?	□Yes □No			
Have you ever felt you needed to cut down on y		_		
Have people annoyed you by criticizing your dri Have you ever felt guilty about drinking?	nking? □ Yes □ No □ Yes □ No			
Have you ever felt you needed a drink first thing			or to get rid of a hangover?	Yes No
Do you smoke cigarettes? 🗌 Yes How many pag	cks per day? For how many y	years?	☐ No ☐ Quit, When? _	
Do you chew tobacco or use snuff?  Yes Tobacco				
Recreational Drug Use / Substance Abuse (injectio				
☐ Heterosexual ☐ Homosexual ☐ Bisexua	-	-		
What type of exercise do you do?			How	often?

CHECK			Name:
CHECK   THE BOX FOR CURRENT PROBLEMS  Your 1 Main Problems (1)	☐ REVIEW OF SYMPTOMS		Date:
Your Main Problems	CHECK THE BOX FOR CURE	RENT PROBLEMS	
□ Fatigue-Weakness □ I don not feet rested when I wake up □ I ann not satisfied with my sleep □ Cough: persistent □ I ann very sleepy during the day □ Coughing blood □ I fall asleep essily during the day □ Coughing blood □ I fall asleep essily during the day □ Coughing blood □ I fall asleep essily during the day □ Couching blood □ I fall asleep essily during the day □ Couching blood □ Deversion Sadness □ Depression Sadness □ Depression Sadness □ Deversion Sadness □ Lave feet down on hopeless for several months □ Have felt down on hopeless for several months □ Have felt down on hopeless for several months □ Patrille interest/joy in usual activities □ Deversion Sadness □ Led fine of the feet of	Your 3 Main Problems: (1)	(2)	(3)
□ Fatigue-Weakness □ I don not feet rested when I wake up □ I ann not satisfied with my sleep □ Cough: persistent □ I ann very sleepy during the day □ Coughing blood □ I fall asleep essily during the day □ Coughing blood □ I fall asleep essily during the day □ Coughing blood □ I fall asleep essily during the day □ Couching blood □ I fall asleep essily during the day □ Couching blood □ Deversion Sadness □ Depression Sadness □ Depression Sadness □ Deversion Sadness □ Lave feet down on hopeless for several months □ Have felt down on hopeless for several months □ Have felt down on hopeless for several months □ Patrille interest/joy in usual activities □ Deversion Sadness □ Led fine of the feet of	General	Lungs	
Il do not feel rested when I wake up			☐ Pain/Bleeding during or after sex
□ am eny stepy during the day □ Coughing blood □ Industry of the day □ Coughing blood □ Industry □ Indu	☐ I do not feel rested when I wake up		
lam very sleepy during the day	☐ I am not satisfied with my sleep		
Unbappines	☐ I am very sleepy during the day		☐ Flushing/Menopause symptoms
Unbappines	☐ I fall asleep easily during the day		
Depression/Sadness	1 1 0 1		
Have felt down or hopeless for several months   Ghortness of breath   Clamps Nodules   Cl			□Pain
TearIndness		Heart/Circulation	□Cysts
Peenings of worthlesenses	☐ Have little interest/joy in usual activities		□ Lumps/Nodules
Peenings of worthlesenses	□ Tearfulness	☐ On exertion ☐ Lying flat	□ Nipple discharge
Concentration difficulty	☐ Feelings of worthlessness		
Excessive irritability		☐ High blood pressure	
□ Lack of motivation □ Palpitations/Racing heart □ Play introduction □ Play interest □ Play introduction □ Play interest □ Play introduction □ Play introduction □ Play interest			
Mondrines	☐ Lack of motivation	☐ Palpitations/Racing heart	Flow:   Heavy   Moderate   Light
Dervousness/Anxiety	□ Moodiness		
District			# of pregnancies
Userplained fever > 100	-	~ ·	# of live births
Frequent night sweats		☐ Leg pain with walking	# of miscarriages/other
Weight gain			Birth control method
Weight gain		□ Cold/Numb feet	Central/Peripheral Nervous System
Allergies			
Anemia			
Phobias			
Mental Illnesses	□ Phobias		☐ Memory loss
Difficulty swallowing	☐ Mental Illnesses		
Persistent nausea/vomiting			
□ I have a mole(s) I want you to check □ Changes in moles/unusual moles □ Are you concerned about skin spots/growths? □ Bruise easily □ Bruise easily □ Bruise easily □ Bruise easily □ Bloody or tarry stools □ Itching □ Hemorrhoids □ Hemorrhoids □ Psoriasis □ Oratipation □ Hepatitis/Jaundice □ Require laxative − How often? □ Excessive hair growth □ Rate Loss □ Cenital/Urinary □ Haria Loss □ Cenital/Urinary □ Hernia □ Dizzy symptoms □ Childhood □ Frequent urination □ Decreased hearing □ Childhood □ Frequent urination □ Dizzy spells - dizziness □ Nose Bleeds - frequent □ Dizzy spells - firequent □ Hoarseness - frequent □ I would like allergy testing □ Street through the search Studies □ Hernia □ Doerrease in force of urination □ Dizes of other of urination □ Dizes of control of urination □ History of sexually transmitted diseases or symptoms or concerns □ Harticipating in Research Studies  Other  Other visual disturbances □ Childrood □ Treaticle lumps/swelling □ Double or blurred vision □ Other visual disturbances □ Chiler visual disturbances □ Chiler visual disturbances □ Chiler visual disturbances □ Chiler visual disturbances □ Constipating □ Diarrhea □	Skin		
Changes in moles/unusual moles			
□ Are you concerned about skin spots/growths? □ Abdominal pain □ Diarrhea □ Back pain - recurrent □ B			
□ Bruise easily □ Diarrhea □ Back pain - recurrent □ Back pain - paint			
□ Rashes       □ Constipation       □ Bone pain/fracture         □ Hives       □ Bloody or tarry stools       □ Gout         □ Itching       □ Hemorrhoids       □ Foot pain         □ Psoriasis       □ Gallbladder problems       □ Gallbladder problems         □ Dry skin       □ Hepatitis/Jaundice       □ Date of last tetanus booster shot         □ Excessive hair growth       □ Require laxative − How often?       □ Have you ever been physically hurt by your partner?         □ Hari Loss       □ Hernia       □ Hernia       □ How often?         □ Hari Loss       □ Hernia       □ Blood transfusion before 1992? □ Yes □ No         □ Hernia       □ Hernia       □ I want sexually transmitted disease testing □ Yes □ No         □ Frequent colds       □ Mon-healing       □ Urine infections - frequent       □ I want HIV testing □ Yes □ No         □ Ringing in the ears       □ Hernia       □ I want HIV testing □ Yes □ No         □ Ringing in the ears       □ Hernia       □ Loss of control of urination         □ Dizzy spells - dizziness       □ Overnight urination x 2       □ Loss of control of urination         □ Dizzy spells - dizziness       □ Dovernight urination x 2       □ Allergy testing         □ Horria discases?       □ Loss of interest in sex         □ Are there sexual issues or dysfunctions you want to discases?       □			
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□ Itching □ Psoriasis □ Gallbladder problems □ Date of last tetanus booster shot □ Have you ever been physically hurt by your partner? □ Are of on the save you ever been physically hurt by your partner? □ Have you ever been physically hurt by your partner? □ Are of on the save you ever been physically hurt by your partner? □ Are work of on the save you ever been physically hurt by your partner? □ Have you ever been physically hurt by your partner? □ Are of on the save you ever been physically hurt by your partner? □ Have you ever been physically hurt by your partner? □ Are of on the save you ever been physically hurt by your partner? □ Have you ever been physically hurt by your partner? □ Are of on the save you ever been physically hurt by your partner? □ Have you ever been physically hurt by your partner? □ Are of on the your partner? □ Are of on the save you ever been physically hurt by your partner? □ Are of on the year. □ No Frequent □ want sexually transmitted in want sexually tran			
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□ Dry skin □ Exessive hair growth □ Require laxative – How often? □ Hair Loss □ Genital/Urinary □ Hernia □ Horine infections - frequent □ Hernia □ Hornia □ Hernia □ Hornia □ Hernia □ Have you ever been physically hurt by your partner? □ Yes □ No □ How transfusion before 1992? □ Yes □ No □ I want sexually transmitted disease testing □ Yes □ No □ Frequent foreign travel? □ Yes □ No □ Hould like more information on □ Allergy testing □ Participating in Research Studies Other Other Other diseases or symptoms or concerns □ Houston Hernia □ Have you ever been physically hurt by your partner? □ Yes □ No □ No □ Have you ever been physically hurt by your partner? □ Yes □ No □ No □ Have you ever been physically hurt by your partner? □ Yes □ No □ Frequent □ I want HIV testing □ Yes □ No □ Frequent foreign travel? □ Yes □ No □ Hould like more information on □ Allergy testing □ Participating in Research Studies Other Other Other diseases or symptoms or concerns □ Houston Have you ever been physically hurt by your partner? □ Yes □ No □ No □ Houston Scale Hernia □ Allergy testing □ Participating in Research Studies Other Other Other diseases or symptoms or concerns □ Houston Have sexually transmitted disease testing □ Yes □ No □ Houston Scale Hernia □ Allergy testing □ Partic			•
□ Excessive hair growth □ Hair Loss □ Require laxative − How often? □ Hair Loss □ Allergy symptoms □ Non-healing □ Decreased hearing □ Childhood □ Ringing in the ears □ Dizzy spells - dizziness □ Nose Bleeds - frequent □ Hoarseness - frequent □ Hoarseness - frequent □ I would like allergy testing □ Watery eyes □ Loss of interest in sex □ Watery eyes □ Double or blurred vision □ Other visual disturbances □ Require laxative − How often? □ Hair Loss □ Require laxative − How often? □ Yes □ No □ I want sexually transmitted or I want HIV testing □ Yes □ No □ Allergy testing □ Participating in Research Studies Other Other Other diseases or symptoms or concerns □ I would like more information on □ Allergy testing □ Participating in Research Studies Other Other Other diseases or symptoms or concerns □ I would like more information on □ Allergy testing □ Participating in Research Studies Ot		-	
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□ Frequent colds			
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□ Ear infections - frequent       irradiation       □ Blood in urine       I would like more information on         □ Dizzy spells - dizziness       □ Overnight urination x 2       □ Allergy testing         □ Nose Bleeds - frequent       □ Loss of control of urination       □ Participating in Research Studies         □ Sore throat - frequent       □ Are there sexual issues or dysfunctions you want to discuss?       Other         □ I would like allergy testing       □ Loss of interest in sex         Eyes       □ Loss of interest in sex         □ Watery eyes       □ Decrease in force of urination         □ Eye Pain       □ Erection problems         □ Double or blurred vision       □ Too rapid ejaculation         □ Other visual disturbances       □ Testicle lumps/swelling	•	•	Trequent foreign travers. In 165 In 176
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□ Nose Bleeds - frequent       □ Loss of control of urination       □ Allergy testing         □ Sinus trouble       □ History of sexually transmitted diseases?       □ Participating in Research Studies         □ Hoarseness - frequent       □ Are there sexual issues or dysfunctions you want to discuss?       □ Other diseases or symptoms or concerns         □ I would like allergy testing       □ Loss of interest in sex         □ Watery eyes       □ Loss of interest in sex         □ Watery eyes       □ Decrease in force of urination         □ Eye Pain       □ Erection problems         □ Double or blurred vision       □ Too rapid ejaculation         □ Other visual disturbances       □ Testicle lumps/swelling			
□ Sinus trouble       □ History of sexually transmitted diseases?       □ Participating in Research Studies         □ Sore throat - frequent       □ Are there sexual issues or dysfunctions you want to discuss?       □ Other diseases or symptoms or concerns         □ I would like allergy testing       □ Loss of interest in sex         □ Watery eyes       □ Decrease in force of urination         □ Eye Pain       □ Erection problems         □ Double or blurred vision       □ Too rapid ejaculation         □ Other visual disturbances       □ Testicle lumps/swelling	· ·		e. c
□ Sore throat - frequent       diseases?       Other         □ Hoarseness - frequent       □ Are there sexual issues or dysfunctions you want to discuss?       □ Uses of interest in sex         □ Watery eyes       □ Loss of interest in sex       □ Decrease in force of urination         □ Eye Pain       □ Erection problems         □ Double or blurred vision       □ Too rapid ejaculation         □ Other visual disturbances       □ Testicle lumps/swelling	-		☐ Participating in Research Studies
□ Hoarseness - frequent       □ Are there sexual issues or dysfunctions you want to discuss?         □ I would like allergy testing       □ Loss of interest in sex         ■ Watery eyes       □ Loss of interest in sex         □ Itchy eyes       □ Decrease in force of urination         □ Eye Pain       □ Erection problems         □ Double or blurred vision       □ Too rapid ejaculation         □ Other visual disturbances       □ Testicle lumps/swelling			
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Eyes □ Loss of interest in sex □ Male □ Itchy eyes □ Decrease in force of urination □ Eye Pain □ Erection problems □ Double or blurred vision □ Too rapid ejaculation □ Other visual disturbances □ Testicle lumps/swelling			
□ Watery eyes       Male         □ Itchy eyes       □ Decrease in force of urination         □ Eye Pain       □ Erection problems         □ Double or blurred vision       □ Too rapid ejaculation         □ Other visual disturbances       □ Testicle lumps/swelling			
□ Itchy eyes □ Decrease in force of urination □ Eye Pain □ Erection problems □ Double or blurred vision □ Too rapid ejaculation □ Other visual disturbances □ Testicle lumps/swelling			
□ Eye Pain       □ Erection problems         □ Double or blurred vision       □ Too rapid ejaculation         □ Other visual disturbances       □ Testicle lumps/swelling			
□ Double or blurred vision □ Too rapid ejaculation □ Testicle lumps/swelling			
☐ Other visual disturbances ☐ Testicle lumps/swelling	-	-	
Explanation:	- Onici visuai distuivances	i resucie tumps/sweming	
	Explanation:		

Rev 6/19



Thank you for selecting our healthcare team. We will strive to provide you with the best possible healthcare. To help us meet your needs, please fill out this form completely. You will be asked to update this information every twelve(12) months due to our changing healthcare environment. We will also ask you for a copy of your Insurance Card(s) and a copy of your Driver's License.

Today's Date Date	of Birth	Preferred Name		
Patient Last Name		First Name		Middle
Address		City/State/Zip _		
Person responsible for payment		Patient relation	ship to responsi	ble party
Address		Phone #		
City/State/Zip				
Primary Phone()	☐OK to leave message on machi ☐OK to leave message with our			
Secondary Phone()	□OK to leave message on machine with detailed appointment / medical information			
Email Address				
Emergency Contact		Relationship		Phone
How were you referred to our office?	P □Friend □Family □Facebo	ook 🗆 Twitter	□Insurance	□Print Ad
Referring Doctor or Facility			Other	

## **Explanation of Complete Physical**

The physical will be performed in two parts. The first part includes blood tests and a discussion with your doctor of medical problems and symptoms you may be having. The office visit and non-routine blood work will be billed under a medical diagnosis. The second part of the physical will include review of your test results. If you are treated for a medical condition during your physical, non-routine fees will be submitted separately from the routine complete physical.

You may wish to contact your insurance company to see if routine benefits are covered. The company may have a maximum dollar limit for routine care. Your physician cannot always be sure that the cost will be under that dollar amount. Our staff can discuss acceptable payment arrangements for any of these services.

## Waiver for possible Non-Covered Service

Routine/preventative services to include but not limited to complete physicals, school, sports, and camp physicals, travel counseling, immunizations, pap smears, well child appointments, and flu shots may not be covered by your insurance company.

I understand that my insurance company may or may not cover these services or labs being performed today. Some insurance companies may pay a portion and others may not cover these services at all. If you have a large deductible, some or all of this may go to your deductible. I understand this and I am willing to be responsible for charges not covered by insurance.

Signature (Patient/Guardian)	Date	06/2019