# Premier Medical Specialists Patient General Health Screening

## Patient Information

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

E-mail Address | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native, ☐ Asian, ☐ Black or African American, ☐ More than one race, ☐ Native Hawaiian or Other Pacific Islander, ☐ White, ☐ Other Race _____, ☐ Unknown

Ethnicity: ☐ Hispanic or Latino, ☐ Not Hispanic or Latino

Primary Language: ☐ English, ☐ Armenian, ☐ Bosnian, ☐ Chinese, ☐ French, ☐ German, ☐ Hebrew, ☐ Japanese, ☐ Russian, ☐ Spanish, ☐ Other_____

## Emergency Contact

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

E-mail Address | Relationship

## Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ BC/BS

Other (Please Specify): _____ Effective Date: _____ / _____ / _____

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Address of policy holder if not the same as Patient's

City | State | Zip Code

Phone: (_____) _____ - _____ Social Security Number of Policy Holder: _____-___-_____

Insurance Identification Number: _____ Group Identification Number: _____

## Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: _____

Can we contact you at work? ☐ Yes ☐ No

Name of Employer (Company Name) Occupation

Phone Number: (_____) _____ - _____

Address

City | State | Zip Code

## Advance Directives

Date Reviewed: _____ ☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy

## Medications

List all medications you take, prescription and nonprescription, and their dosage: ☐ No medications

| Medication | Dose |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

## Allergies

Please list any allergies and types of reactions to any medications or foods: ☐ No allergies

| Medication/Food | Reaction | Medication/Food | Reaction |
|---|---|---|---|
| Medication/Food | Reaction | Medication/Food | Reaction |
| Medication/Food | Reaction | Medication/Food | Reaction |

## Past Medical History

Please check if you have ever experienced any of the following conditions. Please include the date of experience. ☐ No past med hx

| | | | | | |
|---|---|---|---|---|---|
| ☐ Alcohol dependence | ____/____/____ | ☐ Diabetes Type I | ____/____/____ | ☐ Hepatitis | ____/____/____ |
| ☐ Allergies | ____/____/____ | ☐ Diabetes Type II | ____/____/____ | ☐ Kidney stones | ____/____/____ |
| ☐ Anemia | ____/____/____ | ☐ Diarrhea | ____/____/____ | ☐ Other kidney disease | ____/____/____ |
| ☐ Angina | ____/____/____ | ☐ Disc degeneration | ____/____/____ | _____ | |
| ☐ Anxiety | ____/____/____ | ☐ Duodenal ulcer | ____/____/____ | ☐ Liver disease | ____/____/____ |
| ☐ Arthritis | ____/____/____ | ☐ Emphysema | ____/____/____ | ☐ Low blood pressure | ____/____/____ |
| ☐ Asthma | ____/____/____ | ☐ Esophageal reflux | ____/____/____ | ☐ Migraines | ____/____/____ |
| ☐ Blood clots | ____/____/____ | ☐ Gallbladder stones | ____/____/____ | ☐ Mixed hyperlipidemia | ____/____/____ |
| ☐ Broken bones | ____/____/____ | ☐ Goiter | ____/____/____ | ☐ Obesity | ____/____/____ |
| ☐ Cancer | ____/____/____ | ☐ Gout | ____/____/____ | ☐ Osteoarthritis | ____/____/____ |
| Type: _____ | | ☐ Headache | ____/____/____ | ☐ Osteoporosis | ____/____/____ |
| ☐ Chronic blood thinner use | ____/____/____ | ☐ Heart attack | ____/____/____ | ☐ Palpatations | ____/____/____ |
| ☐ Chronic bronchitis | ____/____/____ | ☐ Heart disease | ____/____/____ | ☐ Peptic Ulcer Disease | ____/____/____ |
| ☐ Chronic fatigue syndrome | ____/____/____ | ☐ Other heart disease | ____/____/____ | ☐ Rheumatoid Arthritis | ____/____/____ |
| ☐ Chronic hepatitis | ____/____/____ | _____ | | ☐ Sciatica | ____/____/____ |
| ☐ Chronic kidney disease | ____/____/____ | ☐ Heart failure | ____/____/____ | ☐ Seizures/epilepsy | ____/____/____ |
| ☐ Chronic neck pain | ____/____/____ | ☐ Hepatitis | ____/____/____ | ☐ Sleep apnea | ____/____/____ |
| ☐ Chronic sinusitis | ____/____/____ | ☐ High blood pressure | ____/____/____ | ☐ Stomach ulcer | ____/____/____ |
| ☐ Circulatory disease | ____/____/____ | ☐ High cholesterol | ____/____/____ | ☐ Stroke (CVA) | ____/____/____ |
| ☐ Colitis | ____/____/____ | ☐ Irregular heart rhythm | ____/____/____ | ☐ Thyroid disease | ____/____/____ |
| ☐ Congestive heart failure | ____/____/____ | ☐ Hypertension | ____/____/____ | ☐ Tinnitus | ____/____/____ |
| ☐ COPD | ____/____/____ | ☐ Hyperthyroidism | ____/____/____ | ☐ Tuberculosis | ____/____/____ |
| ☐ Crohn's disease | ____/____/____ | ☐ Insomnia | ____/____/____ | ☐ Other: | ____/____/____ |
| ☐ Depression | ____/____/____ | ☐ Irritable bowel syndrome | ____/____/____ | _____ | |

## Surgical History

Please check all that apply.

| | Date | | Date | | Date |
|---|---|---|---|---|---|
| ☐ Angioplasty | _____ | ☐ Cholecystectomy | _____ | ☐ Liver biopsy | _____ |
| ☐ Angioplasty w/ stent | _____ | ☐ Colectomy | _____ | ☐ Open Reduction Internal Fixation | _____ |
| ☐ Appendectomy | _____ | ☐ Colostomy | _____ | | |
| ☐ Arthroscopy knee | _____ | ☐ Gastric bypass | _____ | ☐ Pacemaker | _____ |
| ☐ Back surgery | _____ | ☐ Hernia repair | _____ | ☐ Small bowel resection | _____ |

- ☐ Coronary Artery Bypass Graft _____
- ☐ Carpal tunnel release _____
- ☐ Cataract extraction _____
- ☐ Other: _____
- ☐ Hip replacement _____
- ☐ Knee replacement _____
- ☐ LASIK _____
- ☐ Thyroidectomy _____
- ☐ Tonsillectomy _____

## Female Surgical History

| | Date | | Date |
|---|---|---|---|
| ☐ Augmentation mammoplasty | _____ | ☐ Mastectomy | _____ |
| ☐ Bilateral tubal ligation | _____ | ☐ Myomectomy | _____ |
| ☐ Breast biopsy | _____ | ☐ Reduction mammoplasty | _____ |
| ☐ Cesarean section | _____ | ☐ TAH/BSO (Total Abdominal Hysterectomy) / (Bilateral Salpingo-Oophorectomy) | _____ |
| ☐ D and C (Dilation and curettage) | _____ | | |
| ☐ Hysterectomy | _____ | ☐ Vaginal hysterectomy | _____ |
| ☐ Other: _____ | _____ | | |

## Male Surgical History

| | Date | | Date |
|---|---|---|---|
| ☐ Prostate biopsy | _____ | ☐ Vasectomy | _____ |
| ☐ TURP (Trans-Urethral Resection of the Prostate) | _____ | ☐ Other: _____ | _____ |

## Family History

Please check if any family member has had any of the following conditions

**Adopted** ☐

| | Mother | Father | Children | Maternal Grandma | Maternal Grandpa | Paternal Grandma | Paternal Grandpa | Uncle | Aunt | Brother | Sister |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ ADD/ADHD | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Alcoholism | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Allergies | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Alzheimer's disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Blood disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Heart disease before age 50 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Cancer (List Type) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Developmental delay | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Eczema | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Hearing deficiency | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ High cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Inflammatory Bowel Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Kidney disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Learning disability | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Mental illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Migraines | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Obesity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Peripheral Vascular Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Stroke (CVA) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Social History

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Do you use tobacco? ☐ Yes ☐ No ☐ Former Type of tobacco used? _____/_____
Packs per day? _____ Years smoked? _____ Year Quit? _____
Other Tobacco units per day (cans, cigars, etc)? _____
Units per day? _____ Years used?_____ Year Quit? _____

Do you drink caffeine? ☐ Yes ☐ No Type? _____ Amount Daily? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Former Year Quit? _____
Type? _____ How much per week? _____
Amount? _____ Last Drink? _____

Do you use recreational drugs? ☐ Yes ☐ No ☐ Former Year Quit? _____
Type? _____ How much per day?_____
Have you ever sought treatment for drug abuse? ☐ Yes ☐ No

Sexually active: ☐ Yes ☐ No ☐ Previously Orientation: _____ #of current partners:_____
Practices safe sex: ☐ Yes ☐ No ☐ Sometimes Detail:_____ # of lifetime partners:_____
Birth Control:_____

Do you exercise? ☐ Yes ☐ No How often: _____ Types of exercise?_____

Do you have problems with sleep? ☐ Yes ☐ No Average hours of sleep per night?_____

## Immunizations

Adult Immunizations – Please check and indicate the immunization date to all that apply.

| | Series # 1 | Series # 2 | Series # 3 | Series # 4 | Series # 5 | Date of last |
|---|---|---|---|---|---|---|
| ☐ Hepatitis B (HBV) | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ | |
| ☐ Pneumococcal (PPV23) | __/___/____ | __/___/____ | | | | |
| ☐ Measles, Mumps, Rubella (MMR) | __/___/____ | __/___/____ | | | | |
| ☐ Varicella (Chicken Pox) (VAR) | __/___/____ | __/___/____ | | | | |
| ☐ Influenza (LAIV) | __/___/____ | __/___/____ | | | | __/___/____ |
| ☐ Meningococcal (MCV4/MPSV4) | __/___/____ | __/___/____ | | | | |
| ☐ Tetanus & Diphtheria (Td) | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ |
| ☐ Adult Tetanus, Diphtheria, Pertussis (Tdap) | __/___/____ | | | | | |
| ☐ Hepatitis A (HAV) | __/___/____ | __/___/____ | __/___/____ | | | |
| ☐ Varicella Zoster (ZOS) | __/___/____ | | | | | |
| ☐ Human Papillomavirus (HPV) | __/___/____ | __/___/____ | __/___/____ | | | |
| ☐ Other: _____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ |
| ☐ Other: _____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ |
| ☐ Other: _____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ | __/___/____ |

### Health Maintenance

| | | | Date of last |
|---|---|---|---|
| Lipid Panel | ☐ Yes | ☐ No | ____/____/_____ |
| Stool cards for hidden blood | ☐ Yes | ☐ No | ____/____/_____ |
| History and Physical | ☐ Yes | ☐ No | ____/____/_____ |
| Colonoscopy | ☐ Yes | ☐ No | ____/____/_____ |
| Sigmoidoscopy | ☐ Yes | ☐ No | ____/____/_____ |
| Influenza Vaccine | ☐ Yes | ☐ No | ____/____/_____ |
| Pneumococcal Vaccine | ☐ Yes | ☐ No | ____/____/_____ |
| Tetanus Vaccine | ☐ Yes | ☐ No | ____/____/_____ |
| DEXA Scan | ☐ Yes | ☐ No | ____/____/_____ |
| Gyn Exam | ☐ Yes | ☐ No | ____/____/_____ |
| PAP | ☐ Yes | ☐ No | ____/____/_____ |
| Mammogram | ☐ Yes | ☐ No | ____/____/_____ |
| Breast Exam | ☐ Yes | ☐ No | ____/____/_____ |

### Disease Management

| | | | Date of last |
|---|---|---|---|
| Abdominal Ultrasound | ☐ Yes | ☐ No | ____/____/_____ |
| Cardiac Stress Test | ☐ Yes | ☐ No | ____/____/_____ |
| Chest X-Ray | ☐ Yes | ☐ No | ____/____/_____ |
| Echocardiogram | ☐ Yes | ☐ No | ____/____/_____ |
| EKG | ☐ Yes | ☐ No | ____/____/_____ |
| Eye Exam | ☐ Yes | ☐ No | ____/____/_____ |
| Foot Exam | ☐ Yes | ☐ No | ____/____/_____ |
| Pulmonary Function Tests | ☐ Yes | ☐ No | ____/____/_____ |

**Do you have any of the following health problems? (circle all that apply)**

| | |
|---|---|
| General: | Weight loss or gain, appetite change, well-being, fatigue, feeling full before you have finished a meal |
| Dermatologic (Skin): | Rashes, dry skin, bruises easily, sweating, itching, hair problems, nail problems, non-healing sores/ulcers |
| Endocrine and Metabolic(hormones): | Excess thirst, thyroid problems, cholesterol/lipid problems, excess sweating |
| Blood/Lymphatic: | Anemia, lymph node enlargement, bleeding problem, frequent infections, lumps under arms or in groin |
| Eyes: | Changes in vision, glasses/contacts, red eye, spots, or halos, eye pain, glaucoma, macular degeneration |
| Ears: | Infections, earaches, discharge, buzzing, mastoid problems, hearing loss |
| Nose and throat: | Sinusitis, nasal stuffiness, bloody nose, sore throat, hoarseness, tonsillitis, taste change, teeth, gums, dentures, morning cough |
| Pulmonary (lungs): | Shortness of breath, cough, sputum, bronchitis, asthma, night sweats, wheezing, cough up blood |
| Cardiovascular (heart): | Chest pain, heart attack, heart failure, swelling in the legs, palpitations or irregular heartbeat, leg cramps with walking, high blood pressure, wake up short of breath |
| Gastrointestinal(stomach and intestines): | Heartburn,/indigestion, difficulty swallowing, stomach pains, nausea, vomiting, diarrhea, rectal bleeding, black bowel movements, change in bowel habits, constipation, frequent laxatives, jaundice, liver trouble |
| Genito-urinary(kidneys and bladder): | Burning on urination, frequency of urination, difficulty starting urine, wet pants or bed, bloody urine, kidney stones, discharge, sexual difficulties, vaginal itching, or bleeding in any form |
| Musculoskeletal: | Joint pain, joint swelling or warmth, joint stiffness, muscle pain, weakness, back pain,joint deformity |
| Neurological(brain/nerves): | Headaches, dizziness, blackouts, numbness, tingling, paralysis, convulsions, seizures, coordination trouble |
| Psychiatric: | Anxiety, nervousness, depression, sadness, trouble concentrating, memory problems, have seen a psychiatrist or psychologist |
| Breast: | Lumps, pain, discharge |
| Sleep: | Difficulties falling asleep, awakes at night, tired during the day, stops breathing at night for short periods, snores, kicks covers |

Special problems or symptoms:_____

Do you have a preferred pharmacy? ❑ Yes ❑ No

Pharmacy: _____ Phone Number: _____

Address: _____

Pharmacy: _____ Phone Number: _____

Address: _____

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I verify that the information that I have provided on this Health Screening Form is accurate and complete.

_____ _____

Patient or Patient's Power of Attorney's Signature Date

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**Physicians Notes:**

I verify that I have fully reviewed this patient's health screening form.

_____ _____

Physician's signature Date