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	___/___/_____

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	___/___/_____

Breast Exam ☐ 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: _____

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

Physicians Notes:

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

_____ _____

Premier Medical Specialists
Timothy J. McCann, M.D.
3338 Watson Road
St. Louis, MO 63139
314-647-0554

Joint Notice of Privacy Practices (NPP) Acknowledgement

A notice of Privacy Practices is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restriction on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Joint Notice of Privacy Practice (NPP), and is the patient, or the patient's personal representative.

Name of Patient or Patient's Personal Representative

Relationship of Personal Representative to Patient (if applicable)

Signature of Patient or Patient's Personal Representative

If applicable, reason patient's written acknowledgement could not be obtained

Signature of Staff Completing Above Section

Printed Name

Notice Date

Notice version: September 23, 2013