Premier Medical Physicians General Health Screening

This section for office use.
☐ New patient ☐ Established patient

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

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 and date of birth of the 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

Patient Name: **DOB:**

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

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: _____

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.

_____ _____

Physician's signature Date