MULTICARE ASSOCIATES
MEDICAL CENTERS

ADULT PREVENTIVE PHYSICAL EXAM INSTRUCTIONS

You are scheduled to check in at _____ for your appointment with _____

on_____at_____AM/PM at our _____ location.

Your provider has given you an extended appointment time for your preventive exam.
*If you are unable to make your appointment, please call at least 24 hours in advance at **763-785-4500**.*
Thank you for your cooperation.

Enclosed are the adult preventive physical **forms** you will need to fill out. **Please complete and bring this packet with you to your appointment.** This information is extremely valuable for your provider to have when you check in for your appointment. **If you do not bring these completed forms with you, we may need to reschedule your appointment.** It is also very important for the provider to know all the medications and/or treatments you are taking. Therefore, please be sure to bring all your medications with you to your appointment.

What is included in your preventive exam (annual physical):

- Review your past medical, social, and family history
- Complete physical exam
- Discuss screening tests or services you may be due for
- Medication review
- Education/counseling on how to improve your health and prevent disease

What is not included in a preventive exam (annual physical):

- Monitoring a problem or condition you already have, including lab tests and medication refills
- Treatment of problems found during the preventive exam
- Treating an acute illness (cold, flu, bad cough, back pain, etc.)

If any of these types of services are provided, you may owe a copay.

Insurance companies require that preventive care and medical treatment be billed separately which means that if your insurance pays for preventive care at 100% ,but you are **treated for something in addition to the preventive exam and are billed an office visit, you may be charged a copay or it may be applied to your deductible**.

You can choose to schedule a separate appointment to address those concerns, or if time permits, you and the provider can address them at the time of your physical with the understanding there may be an additional office visit charge.

SEE REVERSE SIDE FOR MORE INFORMATION

FASTING INSTRUCTIONS

MORNING APPOINTMENTS ONLY: Do not take anything by mouth 12 hours prior to the exam. Please take your medications and drink plenty of water. Avoid all alcohol for at least 72 hours before your appointment.

AFTERNOON APPOINTMENT: Do not come in fasting. Your provider may have you return at a later date for an early morning lab appointment for lab work you may need. Be sure to take your medications.

Attention Patients who are 65 Years and Older

All preventive physical exams, for patients who are 65 years and older, now include Medicare's wellness visit components- also known as the Welcome to Medicare Exam (IPPE), Initial Wellness Visit (IWV) or Annual Wellness Visit (AWV). The Medicare Wellness portion of the visit is at **no cost to you.**

We look forward to seeing you. If you have any questions, please do not hesitate to contact the clinic.

763-785-4500

MULTICARE ASSOCIATES

Adult Wellness Physical- Male Ages 65 and older

Name:_____ Date of Birth:_____ Provider/Physician_____

PATIENTS MUST COMPLETE ALL PAGES

Medications- Please list all medications you are taking: Include dosage and frequency of each as well as vitamins, over-the-counter and herbal products:

_____

_____

Medication Allergies: _____

Latex Allergy: ○ Yes ○ No

Past Medical History (check any condition or disease you've had)

- ○ Allergies: **What type** _____
- ○ Anemia
- ○ Angina
- ○ Anxiety
- ○ Arthritis **Type** _____
- ○ Asthma
- ○ Atrial fibrillation
- ○ Blood Clots: **Where**_____
- ○ Cancer: **Type** _____
- ○ Cardiac arrhythmia (irregular heart rate)
- ○ COPD
- ○ Coronary (Heart) artery disease: **Type**_____
- ○ Depression
- ○ Diabetes- **What type**: ○1 ○2 ○gestational
- ○ Elevated Lipids (high cholesterol): **Type**_____
- ○ Gallbladder disease
- ○ GERD
- ○ Headache, migraine
- ○ Heart disease
- ○ Heart valve disorder
- ○ Hepatitis/liver disease **Type** _____
- ○ Hypertension (high blood pressure)
- ○ Irritable bowel disease
- ○ Myocardial Infarction (heart attack)
- ○ Osteoporosis
- ○ Renal (kidney) disease
- ○ Seizure disorder
- ○ Stroke
- ○ Thyroid disease
- ○ Other: _____

Past Surgical History	Year		Year
Angio w/ stent		D and C	
Angioplasty (heart/extremity)		Gallbladder removed	
Appendix removed		Gastric bypass	
Arthroscopy of Joint (specify)		Hernia repair (specify type)	
Back Surgery upper/mid/lower		Hip replacement L/R/Both	
Blood Transfusion		Hysterectomy	
Bilateral tubal ligation		Knee replacement L/R/Both	
Breast augmentation (implants)		LASIK	
Breast biopsy		Liver biopsy	
Breast reduction		Mastectomy L/R/Both	
Cardiac pacemaker		Ovaries & fallopian tubes removed	
Carpal tunnel release L/R/Both		Surgery for broken bones (ORIF)	
Cataract extraction L/R/Both		Thyroid removed	
Cesarean section		Tonsils removed	
Colon resection (colectomy)		Uterine fibroids removed	
Colostomy (stool pouch)		Other:	
Coronary artery bypass			

Family History: **Please use the relationship abbreviations shown below to identify who in your family has the disease or health problem**

M= Mother **F**= Father **S**= Sister **B**= Brother **MGM**= Maternal grandmother (your mother's mother) **MGF**= Maternal Grandfather (your mother's father) **PGM**= Paternal grandmother (your father's mother)
PGF= Paternal grandfather (your father's father)

	Relationship	What age	Cause of Death		Relationship	What age	Cause of Death
ADD/ADHD	_____	_____	☐	Genetic disease	_____	_____	☐
Alcoholism	_____	_____	☐	Hearing problems	_____	_____	☐
Allergies (type)	_____	_____	☐	High blood pressure	_____	_____	☐
Alzheimer's	_____	_____	☐	Irritable bowel Syndrome	_____	_____	☐
Arthritis (type)	_____	_____	☐	Learning disability	_____	_____	☐
Asthma	_____	_____	☐	Mental Illness	_____	_____	☐
Blood disorder	_____	_____	☐	Migraines	_____	_____	☐
Cancer (type)	_____	_____	☐	Obesity	_____	_____	☐
Heart Disease(type)	_____	_____	☐	Osteoporosis	_____	_____	☐
Depression	_____	_____	☐	Peripheral vascular disease	_____	_____	☐
Development delay	_____	_____	☐	Kidney Disease	_____	_____	☐
Diabetes (type)	_____	_____	☐	Seizures	_____	_____	☐
Eczema	_____	_____	☐	Stroke	_____	_____	☐
High cholesterol	_____	_____	☐	Thyroid disorder	_____	_____	☐

Social History:

No **Yes**

○ ○ Have you ever used Tobacco? If yes, year you quit_____

○ ○ Drink Alcohol? Number of drinks: _____ Every: Day / Week /Month
○ Former drinker ○ Last drink: _____ (year)

○ ○ Consume Caffeine?
If yes, caffeine type (coffee, soda, energy drinks, pill, tea) _____ Cups per day_____

Occupation (even if you are now retired) _____

Number of Children _____

Marital Status:
○ Single ○ Married ○ Divorced ○ Life partner-same sex ○ Life partner-opposite sex ○ Other: _____

Please mark any of the following symptoms you've had in the past 1 months that are concerning to you

Overall health
☐ All No

No	Yes	
○	○	Chills
○	○	Fatigue
○	○	Fever
○	○	Not feeling well
○	○	Night Sweats
○	○	Weight gain
○	○	Weight loss
○	○	Other

_____

Head/Eyes/Ears/Nose/Throat
☐ All No

No	Yes	
○	○	Ear drainage
○	○	Ear pain
○	○	Eye discharge
○	○	Eye pain
○	○	Hearing loss
○	○	Nasal drainage
○	○	Sinus pressure
○	○	Sore throat
○	○	Visual changes
○	○	Other

_____

Respiratory
☐ All No

No	Yes	
○	○	Chronic cough
○	○	Cough
○	○	Known TB exposure
○	○	Shortness of breath
○	○	Wheezing
○	○	Other

_____

Cardiovascular
☐ All No

No	Yes	
○	○	Chest pain
○	○	Leg Pain
○	○	Feet swelling
○	○	Heart pounding
○	○	Other

_____

Stomach/Intestinal
☐ All No

No	Yes	
○	○	Abdominal pain
○	○	Blood in stools
○	○	Change in stools
○	○	Constipation
○	○	Diarrhea
○	○	Heartburn
○	○	Loss of appetite
○	○	Nausea
○	○	Vomiting
○	○	Other

_____

Genitourinary
☐ All No

No	Yes	
○	○	Dribbling
○	○	Painful urination
○	○	Blood in urine
○	○	High Urine output
○	○	Slow stream
○	○	Urinary frequency
○	○	Urinary incontinence
○	○	Urinary retention
○	○	Other

_____

MALE Reproductive
☐ All No

No	Yes	
○	○	Erectile Dysfunction
○	○	Penile discharge
○	○	Sexual Dysfunction
○	○	Other

_____

Metabolism/Endocrine
☐ All No

No	Yes	
○	○	Cold intolerance
○	○	Heat intolerance
○	○	Always thirsty
○	○	Always hungry
○	○	Other

_____

Neurological ☐ All No

No	Yes	
○	○	Dizziness
○	○	Arm or leg numbness
○	○	Arm or leg weakness
○	○	Problems walking
○	○	Headache
○	○	Memory problems
○	○	Seizures
○	○	Tremors
○	○	Other

_____

Mental Health ☐ All No

No	Yes	
○	○	Anxiety
○	○	Depression
○	○	Insomnia
○	○	Other

_____

Skin/Hair
☐ All No

No	Yes	
○	○	Brittle hair
○	○	Brittle nails
○	○	Hair loss
○	○	Excessive hair
○	○	Hives
○	○	Itching
○	○	Mole changes
○	○	Rash
○	○	Skin lesion
○	○	Other

_____

Muscles/Bones ☐ All No

No	Yes	
○	○	Back pain
○	○	Joint pain: Knee, ankle, shoulder
○	○	Joint swelling
○	○	Muscle weakness
○	○	Neck Pain
○	○	Other

_____

Hematologic (blood)/ Lymphatic
☐ All No

No	Yes	
○	○	Easy bleeding
○	○	Easy bruising
○	○	Large lymph nodes
○	○	Other

_____

Immune System
☐ All No

No	Yes	
○	○	Contact allergies
○	○	Environmental allergies
○	○	Food allergies
○	○	Seasonal allergies
○	○	Other

_____

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HEALTH RISK ASSESSMENT

Name: _____ Date of Birth: _____

Medicare Part B Enrollment Date: _____Race: _____ Ethnicity: _____
Month/Year

ALL INFORMATION IS CONFIDENTIAL

GENERAL HEALTH

In general, how would you say your health is? [] Excellent [] Good [] Fair [] Poor

At any time do you feel concerned for your safety/well-being, in your home or elsewhere? [] Yes [] No

Do you have a living will? [] Yes [] No

Do you have any concerns about your:

Hearing?	[] Yes	[] No	Last screening date _____
Eye sight?	[] Yes	[] No	Last screening date _____
Teeth, mouth or gums?	[] Yes	[] No	Last screening date _____

Do you feel more tired when you wake up than when you fell asleep? [] Yes [] No

Do you have trouble falling asleep or staying asleep? [] Yes [] No

Have you ever been tested, outside Multicare, for diabetes and/or cholesterol? [] Yes [] No

Do you have any urinary incontinence? [] Yes [] No

During the past 4 weeks, how much bodily pain have you generally had?
Please rate your pain on a scale from 0 – 10 where 0 is no pain and 10 is severe pain: _____

LIFE/SOCIAL SATISFACTION (GDS)

Please answer the following questions based on your experience over the past 4 weeks

In general, how satisfied are you with your life?
[] Very Satisfied [] Satisfied [] Dissatisfied [] Very dissatisfied

Have you dropped many of your interests or activities? [] No [] Yes-Sometimes [] Yes-Often

Do you feel that life is empty? [] No [] Yes-Sometimes [] Yes-Often

Do you often get bored? [] No [] Yes-Sometimes [] Yes-Often

Are you in poor spirits most of the time? [] No [] Yes-Sometimes [] Yes-Often

Are you afraid that something bad is going to happen to you? [] No [] Yes-Sometimes [] Yes-Often

Do you feel unhappy most of the time? [] No [] Yes-Sometimes [] Yes-Often

Do you often feel helpless? [] No [] Yes-Sometimes [] Yes-Often

Do you prefer to stay at home, rather than going out and doing new things?
[] No [] Yes-Sometimes [] Yes-Often

Do you feel that you have more problems with memory than most? [] No [] Yes-Sometimes [] Yes-Often

Do you feel pretty worthless the way you are now? [] No [] Yes-Sometimes [] Yes-Often

Do you feel like you have no energy? [] No [] Yes-Sometimes [] Yes-Often

Do you feel that your situation is hopeless? [] No [] Yes-Sometimes [] Yes-Often

Do you think that most people are better off than you are? [] No [] Yes-Sometimes [] Yes-Often

Do you often feel alone or lonely? [] No [] Yes-Sometimes [] Yes-Often

Are you easily angered or do you feel angry a lot of the time? [] No [] Yes-Sometimes [] Yes-Often

Do you feel that you have a lot of stress in your life? [] No [] Yes-Sometimes [] Yes-Often

Do you have a hard time dealing with stress? [] No [] Yes-Sometimes [] Yes-Often

Do you feel nervous in social situations? [] No [] Yes-Sometimes [] Yes-Often

LIFE STYLE & SAFETY (SOCIAL HX)

Type of diet? [] Balanced [] Vegetarian [] Vegan [] Low Carb [] High Fat [] Other_____

How often do you exercise? [] Never [] Daily [] Occasional [] 2-3 times/week [] 3-4 times/week

How would you describe you activity level? [] None [] Light [] Moderate [] Vigorous

Do you use any caffeinated products (coffee, tea, chocolate, soda)? [] Yes [] No

Do you drink alcohol?

[] Yes [] No [] Former **If no, skip the next two questions.**

On days when you drink alcohol, how many alcoholic drinks do you have? _____

Have you ever used tobacco products (cigarettes, cigar, chewing, smokeless, etc.)?

[] Yes [] No [] Former ? **If no, skip the next two questions**

How much do you use daily? _____

If you have quit, at what age did you quit? _____

CONFIDENTIAL INFORMATION:

Are you sexually active? [] Yes [] No **If no, skip the next two questions**.

Do you have a same sex partner? [] Yes [] No

How many current sexual partners do you have? _____

Do you now or have you ever used illicit drugs regularly, occasionally or recreationally?

[] Yes [] No [] Former **If no, skip the next question.**

Type of drugs used _____Frequency _____

Do you always wear a seatbelt when you are in a vehicle? [] Yes [] No

Do you have working smoke detectors in your home? [] Yes [] No

Do you have working carbon monoxide detectors in your home? [] Yes [] No

Do you have firearms (guns) in your home? [] Yes [] No

LIFE STYLE & SAFETY

Have you noticed any change in your ability to take care of yourself or to do any of your usual activities?

[] Yes [] No

Are your family members/friends expressing concern for your ability to take care of yourself?
[] Yes [] No

Have you fallen in the past year? [] Yes [] No

Do you think you have poor balance? [] Yes [] No

Please check the box that best describes your ability to do the following:

Activities	Never	Sometimes	Always
Bathe myself			
Dress myself			
Manage my medications			
Prepare meals			
Wash laundry			
Use the telephone			
Manage my money/pay bills			
Drive a vehicle			
Go up and down stairs			
Walk more than 6 blocks without resting			