Health ONE Castle Rock Family Care
Physician Care℠

Current Patient Health History

Name: _____ Pharmacy Name: _____

DOB: _____ Pharmacy Phone: _____

Please fill out form completely.

Do you have any allergies? ☐ No ☐ Yes (please list below)					
Are you currently taking any Prescription or Over-the-counter medications, herbal remedies or vitamins? ☐ No ☐ Yes (please list below)					
Name of Medication	**Dose (total mg)**	**How many times per day?**	**When do you take it? (Morning, afternoon, night)**	**Name of prescribing doctor?**	**How do you take the medication?**
					☐ Oral ☐ Injection ☐ Dermal
					☐ Oral ☐ Injection ☐ Dermal
					☐ Oral ☐ Injection ☐ Dermal
					☐ Oral ☐ Injection ☐ Dermal
					☐ Oral ☐ Injection ☐ Dermal

Personal Health History			**Women ONLY**		
As a child have you ever had: ☐ Measles ☐Mumps ☐ Rubella			Date of your last Pap:		
☐ Chickenpox ☐ Polio			Have you ever had an abnormal Pap?	No☐	Yes☐
Have you ever had a blood transfusion?	No☐	Yes☐	-If yes, when?		
Do you experience frequent falls?	No☐	Yes☐	Age when periods began?		
Do you have an Advance Directive or Living Will?	No☐	Yes☐	Date last period began: ☐/ ☐/		
Have you had a colorectal cancer screening?	No☐	Yes☐	How many days do your periods last? _____		
-If yes, when was your last?			How would you describe your flow? ☐ Light ☐ Moderate ☐Heavy		
			Do you have pain with your periods?	No☐	Yes☐
Sexual History			Total number of Pregnancies:_____ # of live births: _____		
Are you sexually active? ☐			In the last year have you had:		
-If yes, is your partner: ☐ Male ☐ Female ☐Both			☐ Urinary Tract Infections ☐ Bladder infections ☐ Kidney infections		
How many sexual partners in the last year?	No☐	Yes☐	Do you experience any involuntary urine leakage?	No☐	Yes☐
Do you have a history of sexual abuse/ assault?	No☐	Yes☐	Have you ever had a Mammogram?	No☐	Yes☐
Do you have a history of sexually transmitted infections?	No☐	Yes☐	-If yes, when was your last?		
- If yes, what?			-Where?		
Current method of contraception: _____ ☐ **N/A**					
			Men ONLY		
Social History			Do you urinate at night?	No☐	Yes☐
Do you drink alcohol? ☐			-If yes, how many times?		
-If yes, # drinks/day: # drinks/week:			-Pain or burning with urination?	No☐	Yes☐
Have you ever smoked cigarettes? ☐ Currently ☐ Previously ☐ Never			-Blood in the urine?	No☐	Yes☐
-Packs/day: _____ -# of years: _____			-Has the force of your urination decreased?	No☐	Yes☐
Do you exercise regularly?	No☐	Yes☐	In the last year have you had:		
- If yes, #/week: type:			☐ Urinary Tract Infections ☐ Bladder infections ☐ Kidney infections		
Do you use recreational drugs?	No☐	Yes☐	Any problems emptying your bladder completely?	No☐	Yes☐
-If yes, what type:			Any difficulty or pain with erection or ejaculation?	No☐	Yes☐
Do you drink caffeine?	No☐	Yes☐	Any testicle pain or swelling?	No☐	Yes☐
- If yes, # drinks/wk?			Do you feel burning discharge from your penis?	No☐	Yes☐
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed			Recently had unprotected intercourse with a new partner?	No☐	Yes☐
			Date of last prostate and rectal exam?		

List any medical problems diagnosed by other physicians:

Diagnosis	Physician Name	Diagnosis	Physician Name

Patient's signature: _____ Date: _____

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Annual Physical Exam Acknowledgement

An ***Annual Physical Exam*** is a "wellness" exam designed to provide a comprehensive physical examination in order to screen for disease, promote a healthy lifestyle, and assess a member's potential risk factors for future medical problems.

The Annual Physical Exam includes (based on CMS guidelines):

1. Health History Review
2. Vital signs
3. General appearance
4. Heart exam
5. Lung exam
6. Head and neck exam
7. Abdominal exam
8. Neurological exam
9. Dermatological exam
10. Extremities exam
11. Male physical exam
    - Testicular, hernia, penis, and prostate exams
12. Female physical exam
    - Breast and pelvic exams
13. Counseling to include healthy behaviors and screening services

Any health issues/problems not listed above are NOT considered part of a physical examination!

If you discuss other health concerns and or management of any health concern during your Physical Exam, **an office visit will be charged in addition to your physical and may generate a co-payment as a result.**

Because we care and want to provide you with the most efficient visit as possible, we will not ask you to make another appointment to discuss or manage your health concerns but please understand we are **legally obligated** to assign procedure codes based on the **service provided** to you.

We cannot change the coding later to cause the insurance company to pay for a non-covered service. If both services are billed you may be responsible for paying a co-payment for each service, depending on your insurance coverage.

By signing below, you have read and acknowledge the information stated above.

_____ _____

Patient signature Date

_____

Printed Patient Name