Bestcare Internal Medicine

18 to 64 year old
Annual Preventive Visit

Name: ____________

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The purpose of this visit is to review your current health, determine your risk for certain diseases and work with you to make a plan for how to stay well. It doesn't include evaluation of new health concerns or unstable chronic medical conditions; we'd want to schedule another appointment if you're not feeling well or are concerned about a medical problem, to allow adequate time for evaluation. Depending on time, these may be conducted at the same visit (but incur a separate charge) or may be conducted at a future visit.

Concern(s) you wish to address today: ____

Which medication(s) do you need refilled? ____

We'd like to be sure we're not missing concerning symptoms. Are you experiencing any of these?

☐ Abdominal pain	☐ Fatigue, new or worse	☐ Vision change (recent)
☐ Black/tarry stools	☐ Fever	☐ Watery stools
☐ Bleeding	☐ Headaches, new or worse	☐ Weakness
☐ Blood in stool	☐ Hearing loss, new or worse	☐ Weight change (unintentional)
☐ Breathing difficulty	☐ Heartbeat concerns	☐ Wheezing
☐ Bruising (unusual)	☐ Memory problems	
☐ Chest pain or tightness	☐ Numbness	☐ Breast problem or
☐ Cough	Pain, new or worse	Abnormal vaginal bleeding
☐ Coughing blood	Location________________	☐ Abnormal pap/HPV ________________
☐ Disorganized thinking	Severity from 0-10:_______	☐ Menopause complete
☐ Excessive thirst	☐ Sexual concern	If not, menses normal?
☐ Eye pain	☐ Skin changes (recent)	☐ Yes ☐ No: ________________
☐ Falls	☐ Swallowing problem	Last menstrual period: ____________
☐ Fatigue, new or worse	☐ Swollen ankles	Contraception method: ____________
	☐ Urination change	

☐ **None of the Above**

General Health

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you eat healthy foods most of the time?	☐ Yes	☐ No
Do you always wear your seatbelt when riding in a car?	☐ Yes	☐ No
Have you had dental care within the past 12 months?	☐ Yes	☐ No

In the past 7 days, how many days did you exercise? ____ days. Exercise type: __________________

On days when you exercised, for how long did you exercise? ____ minutes per day

OVER→

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Name: _____

Date of birth: _____

Tobacco Use

☐ No ☐ Yes In the last 30 days, have you used tobacco?

If yes, are you interested in quitting in the next month? ☐ Yes ☐ No

_____ Number of cigarettes per day _____ Number of Years

☐ No ☐ Yes Are you a former smoker? ☐ Yes ☐ No

_____ Number of cigarettes per day _____ Number of Years

Mood

Do you have a history of depression or are you being treated for depression ☐ No ☐ Yes

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐

For Women Only

a. Have you ever been pregnant? Yes ☐ No ☐

If yes, how many times? _____ Number of children? _____ Date of last menstrual period? _____

b. Are you sexually active? Yes No

If yes, how many sexual partners do you have? _____ Is (Are) your sexual partner(s) male or female? ___

c. Do you use birth control? Yes No

If yes, what kind? _____ Date of last Pap smear? _____

d. Have you ever had an abnormal Pap smear? Yes No

If yes, when? _____ Date of last mammogram? _____

e. Do you do breast self-examinations? Yes No

f. Have you ever had a Bone Density Scan? Yes No If yes, year of last scan: _____

For Men Only

a. Are you sexually active? Yes No

If yes, how many sexual partners do you have? _____ Is (Are) your sexual partner(s) male or female? ____

b. Do you do testicular self-examinations? Yes No

c. Have you ever had your PSA checked? Yes No If yes, year of last check: _____

Where appropriate, please circle "yes" or "no" for each question.

7. Do you wear glasses or contact lenses? Yes No Date of Last Exam: _____

9. Do you drink alcohol? Yes No If yes, drinks per day: _____ Per Week: _____ Quit? _____ When? _____

10. Do you use any illegal drugs or have you in the past? Yes No

12. In what year did you get your last tetanus shot? _____

13. Have you ever had the pneumonia vaccine? Yes No

14. Have you ever had a colonoscopy? Yes No If yes, what year was your last one? _____

OVER→

Name: _____

Date of birth: _____

Health Screenings:

Date of Last Physical: _____

Date of Last Tetanus Shot: _____

Date of Last Flu Shot: _____

Date of Last Pneumonia Shot: _____

Date of Last Shingles Shot: _____

Date of Last Tdap: _____

Date of Last Eye Exam: _____

Colonoscopy: _____

FIT (Colon Cancer) Test: _____

Bone Density: _____

Screening Female:

Pap Smear: _____

Mammogram: _____

Screening Male:

Prostate Exam /Screen: _____

Testicular Exam: _____