Patient Name_____**DOB**_____**Date**_____

PHYSICAL EXAM QUESTIONAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems (circle your number)

	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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
If you checked off any problems how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not very difficult ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

1. Are you on a special diet? If yes, what kind?

   _____

2. Do you exercise? How often?

   _____

3. For women over 40yo, when was your last mammogram and where? _____
4. For women and men over 50yo, when was your last Dexascan and where?_____
5. For women and men over 50yo, when was your last colonoscopy and where? _____
6. For women and men over 50yo, when was your last stool occult card done? _____
7. If you are diabetic, when was your last foot exam? _____
8. When was your last eye exam? When and where? _____
9. For Women was your last pap? Was it normal? _____
10. For Women when was your last period? Was it normal? _____
11. Have you received the following vaccines? When and where?

    Flu shot_____ Pneumonia_____Shingles_____

Today you are here for your annual physical exam. This time will be spent managing your ongoing chronic conditions, current medications, and reviewing risk factors as well as necessary vaccines, tests, cancer screening / recommendations, review of family history, counseling, etc. When done in a physician's office, these visits are generally free to the patient with no co-pay. If one or more problem, complaint or acute issue is reviewed and/or treated today, this will NOT bill as a physical exam. Routine Copays, deductible and/or coinsurance will apply. We can reschedule your physical exam for another visit.

Please note, we will not change a diagnosis or procedure code to get claims paid, regardless of what your insurance says. This is considered insurance fraud and is illegal. We do have rules and bylaws we have to abide by.

I have read and understand the above policy. I acknowledge that I am responsible for any copays, deductibles, co-insurance and/or non-covered services.

Signature: _____ Date: _____