Medicare Physical

Carlos Gambirazio, M.D.

Patient Name_____ Birthdate____/_____/____ Today's Date _____

Past Medical History

Have you had or been treated for any of the following medical problems in the past (If yes, mark box and list approximate date of initial diagnosis)

	Date		Date
□ High blood pressure	_____	□ GERD or heartburn	_____
□ Diabetes: □ require insulin	_____	□ Irritable bowel syndrome	_____
□ Heart disease	_____	□ Ulcerative colitis/Crohn's disease	_____
□ Stroke/TIA (mini stroke)	_____	□ Colonic polyps or cancer	_____
□ Asthma	_____	□ Bleeding tendency	_____
□ High Cholesterol	_____	□ Venereal disease (STD)	_____
□ Cancer (include type)	_____	□ Anemia	_____
□ Hypothyroidism	_____	□ Schizophrenia	_____
□ Other thyroid problems	_____	□ Bipolar Disease	_____
□ Liver disease	_____	□ Depression	_____
□ Kidney disease	_____	□ Anxiety	_____
□ Seizures/Epilepsy	_____	□ Other psychiatric condition	_____
□ Migraines	_____	□ Gout	_____
□ Alcohol or drug abuse	_____	□ Rheumatoid arthritis	_____
□ Glaucoma	_____	□ Osteoarthritis	_____
□ Environmental Allergies	_____	□ Chronic Pain	_____
□ Emphysema/COPD	_____	□ Fibromyalgia	_____
□ Pneumonia	_____	□ DVT (clots in legs)	_____
□ Tuberculosis	_____	□ Pulmonary embolism (clot in lung)	_____
□ Other lung conditions	_____	□ Osteoporosis/Osteopenia	_____
□ AIDS or HIV(+)	_____	□ Any other diseases, please list _____	
□ Ulcer or gastritis	_____	□ None of the above	

Since your last physical exam have you had any new surgeries? □ None

_____

Since your last physical exam have you had any new diagnosed medical problems? □ None

_____

Please list your other physicians or specialists

_____

Please list your suppliers for medical supplies (such as oxygen and rented equipment) □ None

_____

Please list allergies to medications including what type of reaction you developed with each □ None

_____

Habits

Smoking (type & amount per day, # of years) _____ □ Non-smoker
If former smoker, # of years smoked_____ date quit _____
Alcohol (type & amount per day)_____ □ Non-drinker
If former use, date quit _____ □ Drink on rare occasion
Caffeine (number of cups per day) _____ □ None
Street Drugs (type & amount per day)_____ □ None
If former use, date quit _____

Have you received any immunizations since your last visit? _____

Do you have a living will? _____ Do you have a power of attorney? _____

Social History

Marital status □single □married □divorced □widowed □live with male partner □live with female partner

Specify number of years in current relationship or since divorced or widowed_____

Current occupation (specify part or full time) _____

Name, relation, and age of people currently living with you_____

_____

_____

Family History

Do you have any close relatives with the following conditions? Yes No

Breast cancer Colon cancer diabetes heart disease

Review of Systems

Usual Weight _____#
Has your weight been stable in the past year?_____ Amt. Gained _____# Amt. Lost _____#
Do you exercise regularly? ____ Type of exercise, how often and how long each time _____
Would you say you eat healthy in general? yes no

If you are diabetic:

- How often do you check your sugars? _____
- What have your sugars been recently? Highest _____ Lowest _____ Average _____
- When was your last eye exam? _____
- Do you follow a diabetic diet? _____
- Do you look at your feet everyday? yes no Any problems?_____
- Have you seen the diabetes educator? yes no When was the last time? _____

If you have hypertension:

- Do you check your blood pressure at home or elsewhere? yes no
  If yes, how often? _____
  Please list your recent readings _____

If you have high cholesterol:

- Have you been following a low cholesterol diet? yes no

Females

□ Hysterectomy □ Postmenopausal (Any postmenopausal bleeding? yes no)

- First day of your last menstrual period? _____
- What type of birth control do you use? _____
- Are your periods regular? _____ Are they heavy? _____
- Are you sexually active? Yes No Any problems with intercourse? _____

Males

- Any problem with sexual function? yes no
- Any testicular lumps? yes no
- Any penile discharge? yes no

Patient Signature _____ Date _____

Physician Signature _____ Date _____