PROVIDENT HEALTHCARE

Appointments Scheduled for Wellness Exams or Annual Physicals

Here are a few things we would like you to know:

- Your yearly physical is scheduled for preventative maintenance and to address preventative care and issues. We also update your health and family history.

- It is not designed to address existing medical conditions/complaints.

- The codes billed to your insurance company or Medicare for that visit do not cover the active management of other health issues or existing conditions.

- If an existing or new issue is addressed during this visit, an appropriate office visit code will be billed in addition to the code for your physical/wellness exam. There may be an applicable copayment , coinsurance or deductible due based upon your insurance coverage.

- The services completed during a physical/wellness exam depends on your age, gender, medical history and whether you are a new or existing patient

- The discussion and treatment you receive during your physical, as well as tests ordered, is up to your provider.

- If testing is ordered for you, we may request that you schedule a follow up visit to discuss any lab results, finalize your plan of care and discuss any follow up questions. A copayment, coinsurance and/or deductible will apply depending upon your insurance.

- You may need to schedule a separate visit for the management of chronic conditions, new complaints/problems or to discuss lab or other test results to ensure the appropriate amount of time is available to care for you.

- We do not send normal lab results to patients. We will make them available to you, upon request, via our secure email service. Please ask a staff member if you would like to enroll in that service. We do not mail test results due to increasing postage and overhead costs.

PROVIDENT HEALTHCARE

Review of Systems Form - Wellness Exam/Annual Physical

Patient Name: _____ **Date of Birth:** _____

Date of Appointment: _____

Have you been diagnosed with or are currently having (within the last 6 months) any of the following? If the response is "No" for an entire category, circle "No" on the top line and skip the remaining part of the section.

Constitutional: Do you have the following:
NO – skip to the next section
YES - please indicate below

Weight Gain _____ Insomnia _____
Weight Loss _____ Fever _____
Fatigue _____ Weakness _____
Chills _____ Night Sweats _____
Lethargy _____

Comments: _____

Hematologic: Do you have the following:
NO – skip to the next section
YES - please indicate below

Easy Bruising _____ Easy Bleeding _____
Blood Clots _____ Swollen lymph nodes _____

Comments: _____
_____
_____

Neurological/ Head, Eyes, Ears, Throat: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Headaches _____
Eyes: Double Vision _____ Redness _____ Pain____ Spots/ Floaters _____
Itching _____ Burning _____ Tearing _____ Discharge _____
Visual Loss: None_____ Right Eye _____ Left Eye _____ Bilateral _____
Corrective Glasses _____ Contacts _____ Both _____ History of: Radial Keratotomy _____ Lasik _____

Ears: Hearing Loss _____
Pain _____
Ringing _____
Discharge _____
Fullness/Plugging _____

Nose & Sinus: Nasal Congestion _____
Facial Pain _____
Obstruction _____
Decreased Smell ____
Allergies _____
Freq. Nose Bleeds _____
Discharge _____
Sneezing _____
Freq. Infections _____

Throat: Freq. Sore Throats _____
Swallowing probs _____
Hoarseness _____
Cold Sores _____
Sore Tongue _____
Change in Taste _____
Tooth Pain _____
Snoring _____

Comments: _____

Respiratory: Do you have the following:
NO – skip to the next section
YES - please indicate below

Chest pain with breathing _____ TB Exposure _____
Shortness of Breath _____ Wheezing _____
Cough _____ Freq. Infections _____

Comments: _____

Cardiovascular: Do you have the following:
NO – skip to the next section
YES - please indicate below

Chest Pain _____ Passing out _____
Swelling in legs/ ankles _____ Palpitations _____
Shortness of Breath with Exertion _____
Shortness of Breath at night _____

Gastrointestinal: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Significant loss of appetite _____ Altered Bowel Habits _____
Weight Loss _____ Abdominal Pain _____
Nausea _____ Abdominal Mass _____
Vomiting _____ Difficulty swallowing (Food Getting Stuck) _____
Vomiting of Blood _____ Acid Reflux _____
Diarrhea _____ Indigestion/ Heartburn _____
Constipation _____ Jaundice _____
Blood in Stool/ Rectal Bleeding _____ Anal Conditions (e.g., hemorrhoids) _____
Abdominal Bloating _____
Comments: _____

Any additional comments: _____
_____
_____
_____

PROVIDENT HEALTHCARE

Review of Systems Form - Wellness Exam/Annual Physical

Patient Name: _____ **Date of Birth:** _____

Genitourinary/ GYN: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Urinary frequency _____ Change in urine color _____ Urinary hesitancy _____
Urinary urgency _____ Back Pain _____ Painful urination _____
Blood in urine _____ Flank Pain _____ Excessive urine _____
Incontinence _____ Decreased Stream _____ Passage of stone/gravel _____
Groin Mass _____ Foul urine odor _____ Cloudy Urine _____
Frequent Urination at Night _____
Comments: _____

Male Reproductive: Do you have the following:
NO – skip to the next section
YES - please indicate below

Scrotum/ Testicular Mass _____ Blood in sperm _____
Genital Herpes _____ Penile Discharge _____
Scrotum/Testicular Pain_____
History of other sexually transmitted diseases: _____

Musculoskeletal: Do you have the following:
NO – skip to the next section
YES - please indicate below

Bone/Joint Symptoms _____
Back Pain _____
Muscle Aches _____

Metabolic/Endocrine: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Voice Change _____ Cold Intolerance _____ Heat Intolerance _____
Hair Loss _____ Coarse Hair _____ Excessive Perspiration _____
Goiter (enlarged thyroid) _____ Chronically Overweight _____ Tremors _____
Chronically Underweight _____ Excessive Thirst _____ Excessive Urination _____
Abnormal Hair Distribution _____ Generalized Weakness _____ Infertility _____
Darkening of Skin _____ History of Abnormal Glucose Tolerance Test _____
Comments: _____

Neurological/Psychiatric: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Vertigo _____ Difficulty enunciating words _____ Seizures _____
Incoordination _____ Fainting _____ Gait Disturbance _____
Numbness _____ Visual Disturbance _____ Dizziness _____
Memory Loss _____ Focal Weakness _____
Psychiatric/ Emotional Concerns _____
Comments: _____

Dermatologic: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Rash _____ Excessive Sweating _____
Changing or concerning moles _____ Nail Changes _____
Acne _____
Comments: _____

Immunological: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Asthma _____ Hay Fever _____ Hives: _____
Contact Dermatitis: _____ Food Allergies: _____ "Bee" Sting Allergies _____
Environmental Allergies: _____ Animals at Home: _____ Animals in Work Place: _____
Chemicals at Home: _____ Chemicals in Work Place: _____
Comments: _____

If you would like to make additional comments, please do so at the bottom of the first page.

I have read the Provident policy regarding wellness exams/annual physicals. I understand that I may receive a statement for any services above and beyond a wellness visit.

_____ _____

Patient Signature **Date**

This page for male patients only.

Patient Name: _____ **Date of Birth:** _____

Date of Visit: _____

What is your Enlarged Prostate (EP) Symptom Score?

Circle one number in each line. Add the numbers from each line to get a total score. Then talk to your provider at your appointment today.

Over the past month, how often have you...	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
stopped and started again several times when you urinated?	0	1	2	3	4	5
found it difficult to postpone urination?	0	1	2	3	4	5
had a weak urinary stream?	0	1	2	3	4	5
had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5 or more times
Over the past month how many times did you typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Score: 1 - 7 Mild 8 - 19 Moderate 20 - 35 Severe

Adapted from American Urological Association.