# QUESTIONNAIRE FOR PHYSICAL WELLNESS EXAMS AND NEW PATIENTS

## Baylor Scott & White Family Medicine- Las Colinas

**Name_____ DOB_____ Date_____**

**Thank you for entrusting your wellness care to us. IF YOU ARE SCHEDULED FOR A PHYSICAL WELLNESS EXAM PLEASE READ THE FOLLOWING:**

We have several things to accomplish with your Physical Wellness Exam:

1. The full physical exam
2. Discussion of preventive health: 1) vaccinations 2) cancer screening 3) Lifestyle medicine
3. Risk assessment: 1) Family history; 2) Current health and weight status 3) Lab work

**Many patients understandably confuse a "complete physical" (preventive visit) with a "comprehensive medical evaluation" (where we address several health issues).** Unfortunately, due both to insurance guidelines and time constraints, health concerns should be scheduled for a different visit. **If a significant amount of time is spent addressing health concerns, an additional office visit will be charged according to your insurance guidelines.** Also, many labs and procedures considered non-preventive by your insurance company are not covered under "preventive care," and may be applied to your deductible and become your full responsibility. In addition, if you are not yet due for your yearly physical, this visit may not be covered under your insurance plan.

_____ **Please initial.** *I have read, understand, and agree to the policy outlined above.*

Please answer the following questions so that we may serve you better:

- What is your marital status (single, married, divorced, widowed)?_____
- What is your occupation?_____
- How many children do you have and what year were they born?_____
- Do you follow a special diet (vegan, vegetarian)? _____
- Do you use tobacco or drugs? NO YES If so, what kind? _____
- History of tobacco or drugs in the past? NO YES If so, what kind, year quit? _____
- What kind of alcohol do you drink? _____ How often? _____
- What is your sexual orientation (not active, heterosexual, homosexual, bisexual)? _____
- How often do you exercise (never, sometimes, most days or everyday)? _____

**Review of Systems:** Please indicate if you are ***currently*** experiencing significant problems with any of the following:

**No Yes (LIST:)**

- ☐ ☐ **Skin**: _____
- ☐ ☐ **Head**: _____
- ☐ ☐ **Eyes**: _____
- ☐ ☐ **Ears**: _____
- ☐ ☐ **Nose**: _____
- ☐ ☐ **Throat**: _____
- ☐ ☐ **Lymphatic** (lymph nodes, swelling): _____
- ☐ ☐ **Cardiac** (heart, blood vessels): _____
- ☐ ☐ **Respiratory** (lungs): _____
- ☐ ☐ **Gastrointestinal** (swallowing, stomach, bowels): _____
- ☐ ☐ **Urinary** (kidney, bladder): _____
- ☐ ☐ **Musculoskeletal** (muscles, bones, joints, tendons): _____
- ☐ ☐ **Neurological** (nerves): _____
- ☐ ☐ **Psychiatric** (mental health): _____
- ☐ ☐ **Genital** (including breasts): _____
- ☐ ☐ **Other**: _____

***If female**:* When was the first day of your **last menstrual period**? ___/___/___