

Adult New Member Physical Form

(within 90 days of enrollment)



Allergies:

Date: _____

Name: _____ ID#: _____ Sex: _____ Age: _____

Address: _____ Phone: _____

Primary Language: English Other List: _____ Advance Directives Acknowledgement: Yes No

◆ **Vital Signs:** BP _____ P _____ R _____ T _____ Ht _____ Wt _____
 Visual Acuity 20/ _____

◆ **Past Medical/Surgical History** _____

◆ **Current Medications:** _____

◆ **Social History:** Alcohol _____ Tobacco _____ Drugs _____ Domestic Violence Screening Y N/A

◆ **Family History:** _____

◆ **Systems Review**

Constitutional	Fever <input type="checkbox"/> Y <input type="checkbox"/> N	Weight Gain <input type="checkbox"/> Y <input type="checkbox"/> N	Renal/Urological Gynecologic	Dysuria <input type="checkbox"/> Y <input type="checkbox"/> N	Urinary hesitancy <input type="checkbox"/> Y <input type="checkbox"/> N
	Weight loss <input type="checkbox"/> Y <input type="checkbox"/> N	Night Sweats <input type="checkbox"/> Y <input type="checkbox"/> N		Hematuria <input type="checkbox"/> Y <input type="checkbox"/> N	Sexual dysfunction <input type="checkbox"/> Y <input type="checkbox"/> N
	Insomnia <input type="checkbox"/> Y <input type="checkbox"/> N				Genital Discharge <input type="checkbox"/> Y <input type="checkbox"/> N
Head and Neck	Visual Changes <input type="checkbox"/> Y <input type="checkbox"/> N	Eye pain <input type="checkbox"/> Y <input type="checkbox"/> N	Musculoskeletal	Joint Pain <input type="checkbox"/> Y <input type="checkbox"/> N	Muscle pain <input type="checkbox"/> Y <input type="checkbox"/> N
	Nasal bleeds <input type="checkbox"/> Y <input type="checkbox"/> N	Sore throat <input type="checkbox"/> Y <input type="checkbox"/> N		Back pain <input type="checkbox"/> Y <input type="checkbox"/> N	Joint swelling <input type="checkbox"/> Y <input type="checkbox"/> N
	Hoarseness <input type="checkbox"/> Y <input type="checkbox"/> N	Pain in gums <input type="checkbox"/> Y <input type="checkbox"/> N	Neurological	H/A <input type="checkbox"/> Y <input type="checkbox"/> N	Seizure <input type="checkbox"/> Y <input type="checkbox"/> N
	Ear pain <input type="checkbox"/> Y <input type="checkbox"/> N	Hearing Loss <input type="checkbox"/> Y <input type="checkbox"/> N		Syncope <input type="checkbox"/> Y <input type="checkbox"/> N	Weakness <input type="checkbox"/> Y <input type="checkbox"/> N
				Ataxia <input type="checkbox"/> Y <input type="checkbox"/> N	Loss of sensation <input type="checkbox"/> Y <input type="checkbox"/> N
					Difficulty speaking <input type="checkbox"/> Y <input type="checkbox"/> N
Respiratory	Dyspnea <input type="checkbox"/> Y <input type="checkbox"/> N	Hemoptysis <input type="checkbox"/> Y <input type="checkbox"/> N	Endocrine	Polyuria <input type="checkbox"/> Y <input type="checkbox"/> N	Polydipsia <input type="checkbox"/> Y <input type="checkbox"/> N
	Cough <input type="checkbox"/> Y <input type="checkbox"/> N	Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N		Fatigue <input type="checkbox"/> Y <input type="checkbox"/> N	
Cardiovascular	Chest pain <input type="checkbox"/> Y <input type="checkbox"/> N	Palpitations <input type="checkbox"/> Y <input type="checkbox"/> N	Hematologic	Anemia <input type="checkbox"/> Y <input type="checkbox"/> N	Easy bruising <input type="checkbox"/> Y <input type="checkbox"/> N
	Pedal Edema <input type="checkbox"/> Y <input type="checkbox"/> N				
Gastrointestinal	Dysphagia <input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N	Immunologic	Hives <input type="checkbox"/> Y <input type="checkbox"/> N	Allergy to foods <input type="checkbox"/> Y <input type="checkbox"/> N
	Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N	Constipation <input type="checkbox"/> Y <input type="checkbox"/> N			
	Melena <input type="checkbox"/> Y <input type="checkbox"/> N	Dyspepsia <input type="checkbox"/> Y <input type="checkbox"/> N			
	Abdominal Pain <input type="checkbox"/> Y <input type="checkbox"/> N				

Examination	√=Normal	Comments (required for abnormal findings)
General		
Head		
EENT		
Neck		
Chest and Lungs		
Breasts		
Cardiovascular		
Abdomen		
GU		
Rectal/Fecal Occult Blood Testing		
Female: Pelvic		
Extremities		

◆ **Diagnosis:** _____

◆ **Plans:** _____

◆ **Diagnostic Studies Ordered:** (required labwork) Urinalysis Hgb/Hct

◆ **Old Records** Requested From Dr: _____ Date: _____

◆ **Screening Requirements**

Cardiac			Diabetes			Female Member		
√=Ordered /Referred	---or---	Date Done/ Result	√=Ordered /Referred	---or---	Date Done/ Result	√=Ordered /Referred	---or---	Date Done/ Result
	LDL-C			HgbA1c			Mammogram	
	MI			LDL-C			PAP Test	
	Beta Blocker			Microalbuminuria			STD screen /Chlamydia	
	CHF			Eye Exam				
	ACE Inhibitor			Immunizations				
	LVEF-Echo or MUGA			Pneumococcal				
				Influenza				

Physician's Name: _____

Signature: _____

Original—send to plan with claim form

Copy—place on member's chart