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**

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

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