WellCare

Adult New Member Physical

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