Dear Patient,

We look forward to taking care of you at your upcoming complete physical exam. Please read the following to ensure an efficient and successful appointment.

There are three things that must be completed prior to your visit.

1. Completely fill out your medical history form and bring a list of all of your current medications- this includes over the counter supplements, vitamins, etc.

2. Complete your at-home stool card and bring with you. Instructions are inside. This is not required if you are > 75 years of age.

3. Please have your bloodwork testing completed 5-7 days before your scheduled appointment.

A complete physical exam includes reviewing diagnostic laboratory tests and ordering any needed preventative screenings, this may include a urine test, EKG, and any additional testing that may be deemed appropriate for your care.

Please do not wear body lotion the day of your appointment.

If you need to cancel your appointment, you are required to give 48-hour notice, otherwise we reserve the right to charge $100. You may call and leave a message with our answering service after normal office hours or on the weekends.

Discussing a new or acute issue at your physical may incur a separate charge to insurance. Most insurances cover physical exams as a preventative service, but you may need to verify this with your insurance company.

Thank you for your cooperation,

The medical providers of Aurora Family Practice Group, P.C.

AURORA FAMILY PRACTICE GROUP, P.C.

ANDREW G. SARKA, M.D.
MARK H. NATHANSON, D.O.
MALLORY JURGENS P.A.-C
EMILY HOWARD P.A.-C
MELANIE MCCOY P.A.- C

Date_____

Patient Name_____

Due to new insurance and Medicare regulations regarding preventive medicine services, it has become necessary to inform you that your complete physical exam **may or may not be covered by your insurance company.** This exam is a comprehensive overview of your current health status. We appreciate your patience and understanding in these new regulations.

Please read all items carefully and initial. If you have any questions, please ask the receptionist. Thank you for your cooperation.

- I understand that I am about to have a complete physical examination. _____
- I have received an information packet, either by mail or by pick up, that explained all the services entailed in this examination. _____
- I understand that I am financially responsible for all the charges in the event my insurance company denies all or any part of these services. _____
- I am aware that my insurance may not cover preventive medicine services and fully understand my financial obligation. _____
- I understand that I may decline any service prior to receiving them. _____

Patient Signature: _____

1550 SOUTH POTOMAC, SUITE 370 AURORA, COLORADO 80012-5454 Phone (303) 369-1080 Fax (303) 750-4913

Patient Name_____ Date of Birth: _____ Date_____

Health Risk Assessment Form

Please complete all sections before seeing your provider

In general, my overall health is: ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

List any hospitalizations, major illness, or visits to the emergency room since last year or last visit

Date	Reason	Location

Medical History

Personal and Family Medical History	☐ No changes since last year/visit					
	Me	Father	Mother	Siblings	Children	Specify Disease
Coronary Disease						
High Blood Pressure						
High Cholesterol						
Cerebral Vascular Disease / Stroke						
Renal Disease						
Cancer						
Diabetes						
Aortic Aneurysm						
Amputation		Location:		Do you use a prosthetic: Y/N		

Past Surgeries	Date	Past Surgeries	Date

Names of All Providers / Specialists You See:

Doctor's Name	Specialty Type and Reason You See Them

Patient Name_____ Date of Birth: _____ Date_____

List of Medical Equipment/Service Providers

Supply	Who provides this service for you?
Oxygen/CPAP	
Diabetic Supplies	
Home Health	
Other	

Changes in medications or allergies since last year or last visit ☐ No changes since last year/visit

New patients may document additional medications on the back of this form

Medication	Dose	Reason for Taking

Allergies	Reaction	Allergies	Reaction

Medications: What pharmacy fills your prescriptions? _____

Are you having trouble taking your medications as prescribed? Yes ☐ No ☐

Are you interested in having your prescriptions sent to your home? Yes ☐ No ☐

Accident Prevention:

Do you wear seatbelts in the car? ☐ Yes ☐ No

Do you have smoke detectors at home? ☐ Yes ☐ No

Do you have carbon monoxide detectors? ☐ Yes ☐ No

Do you have firearm(s) at home? ☐ Yes ☐ No If yes, locked up? ☐ Yes ☐ No

Activities of Daily Living

Do you require assistance with any of the following activities?

Using the telephone	☐ Yes ☐ No	Eating	☐ Yes ☐ No
Shopping	☐ Yes ☐ No	Getting from bed to chair	☐ Yes ☐ No
Meal preparation	☐ Yes ☐ No	Dressing	☐ Yes ☐ No
Housekeeping	☐ Yes ☐ No	Bathing	☐ Yes ☐ No

Patient Name_____ Date of Birth: _____ Date_____

Do you drink alcohol? ☐ Yes ☐ No ☐ I No longer drink alcohol
How many times in the last year have you had more than 5 drinks (male)/4 drinks (female) in one day? ____
☐ I'm interested in talking more about my alcohol use

Have you ever smoked or chewed tobacco or smoked marijuana? ☐ No ☐ Yes ☐ Current: _____ per day
☐ I'm interested in help to stop using _____

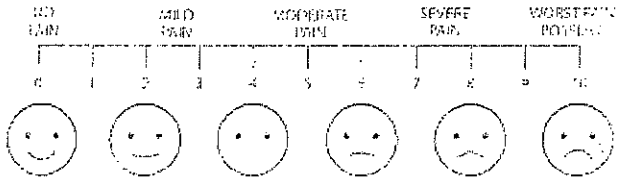
Do you use illicit drugs? ☐ No ☐ Yes ☐ I'm interested in help to stop using _____

Do you ever take prescription drugs for non-medical reasons? ☐ No ☐ Yes
If yes, how often? ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily
☐ I'm interested in talking more about prescription drug use

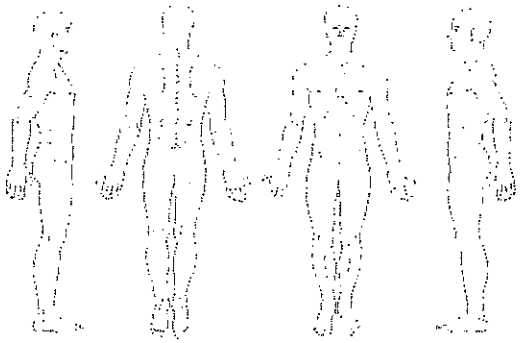
Pain Assessment

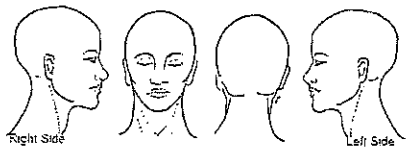
Do you have pain? ☐ Yes ☐ No
Is the pain constant? ☐ Yes ☐ No
Type of pain: ☐ Ache ☐ Deep ☐ Sharp ☐ Hot ☐ Cold ☐ Sensitive skin ☐ Other: _____
Onset, duration, and variation: _____

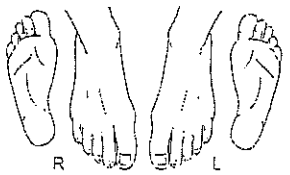
Intensity: on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how is your pain right now?



Mark location of pain on diagrams below:







What relieves the pain? _____

I'm interested in other options to manage my pain: ☐ Yes ☐ No

Do you see a specialist to manage your pain? ☐ Yes ☐ No Specialist: _____

Do you have a prescription for pain medication? ☐ Yes ☐ No
If yes, ☐ Post-surgery (short term) or ☐ Chronic pain

Patient Name_____ Date of Birth: _____ Date_____

Laundry	☐ Yes ☐ No	Walking	☐ Yes ☐ No
Driving/taking taxi or bus	☐ Yes ☐ No	Getting on/off toilet	☐ Yes ☐ No
Taking medications	☐ Yes ☐ No	Urinary/Bowel Incontinence	☐ Yes ☐ No
Handling finances	☐ Yes ☐ No		

Would you like to speak to your provider about bladder control or trouble with urinary leakage? ☐ Yes ☐ No

I have someone available to help if needed (for a sick day) ☐ Yes, any time ☐ Yes, sometimes ☐ Not really

Personal concern about your memory - or family mentions concern ☐ Yes ☐ No

Diet: ☐balanced ☐vegetarian ☐diabetic ☐low salt ☐low fat ☐low carb ☐other: _____

Do you exercise every day? ☐ No ☐ Yes If not daily, how often? _____

Have you had any falls in the past year? ☐ No ☐ Yes If yes, any injuries: _____

I use a: ☐ cane ☐ prosthetic ☐ walker ☐ wheelchair/scooter ☐ other: _____

In the last two weeks check (√) how often you have been bothered by the following:	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have Noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
8. Moving or speaking so slowly that other people could have Noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more				
Add columns for total score:				

If you checked *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Patient Name_____ Date of Birth: _____ Date_____

If you have a prescription for pain management, please complete:

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal Drugs	2	3
Rx Drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal Drugs	4	4
Rx Drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Health Screenings:

Do you have trouble with speech? ☐ Yes ☐ No

Do you have trouble hearing? ☐ Yes ☐ No Do you wear a hearing aid? ☐ Yes ☐ No

Last hearing exam: _____

Do you have trouble seeing? ☐ Yes ☐ No Do you wear glasses or contacts? ☐ Yes ☐ No

Most recent diabetic retina (dilated) eye exam: ☐ I'm not a diabetic

- Mo/Yr _____/_____
- By Dr. _____ Ophthalmologist / Optometrist (please circle one)
- Location (name of eye doctor's office, if known) _____
- Result of retina exam _____ (e.g., negative for retinopathy)

When was your most recent:

Mammogram: Mo/Yr: _____Where: _____Result: _____

Patient Name_____ Date of Birth: _____ Date_____

Colonoscopy: Mo/Yr: _____Where: _____ Result: _____

I elected another colon test: ☐ FIT-DNA year_____ Result: _____

☐ FOBT year_____ Result: _____

☐ Other colon screening: _____ Yr._____Result: _____

Osteoporosis Screening (DEXA) bone scan:

- Mo/Yr _____/_____ Location: _____ (Name of imaging center)
- ☐ I received my bone scan in my home

I have a: ☐ Living will ☐ Medical Order for Life Sustaining Treatment (MOST)

☐ Medical Power of Attorney ☐ Other: _____

☐ **I'm interested in learning more about documenting my wishes for end-of-life decision-making**

I'd like to talk with a Care Coordinator about _____.

A Care Coordinator can assist with managing chronic diseases like diabetes, heart failure and COPD. They can help find options for: reducing cost of medications, transportation, long-term care planning, caregiver support, end of life decision-making, resources for mental health or substance abuse.

_____ Provider Signature (reviewed)

☐ No cognitive issues detected ☐ Cognition screen prompts Mini-Cog or SLUM, results and plan in visit note.

For Office Use Only

Referral to Care Coordinator completed _____ (initials)

Personalized Preventive Plan of Services (PPPS) completed and given to patient: _____ (initials)

Sleep Disorder Symptoms Assessment

Date _____

Name: _____

Date of Birth: ____/____/____ Gender: M____F____
(MM/DD/YY)

FOR OFFICE USE:
Height: _____
Weight: _____
BMI: _____
Neck Size: _____
Blood Pressure: _____

Please check any of the following you may have:			
☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night (Nocturia)	☐ Diabetes	☐ Depression	☐ Overweight

Snoring:		Score
1. Do you snore often (3 or more nights a week)?	☐ YES ☐ NO ☐ Don't Know	____ Yes = 1
2. Is your snoring loud enough to be heard through a closed door or annoy other people?	☐ YES ☐ NO ☐ Don't Know	____ Yes = 1
3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air?	☐ YES ☐ NO ☐ Don't Know	____ Yes = 2
(sum of all numbers checked above) Total Score		

Epworth Sleepiness Scale:	Never would doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1 Do you get sleepy, or doze off, while sitting and reading?	0☐	1☐	2☐	3☐
2 Do you get sleepy, or doze off, while watching TV?	0☐	1☐	2☐	3☐
3 While sitting or inactive in a public place (meeting, theater)?	0☐	1☐	2☐	3☐
4 As a passenger in a car for an hour without a break?	0☐	1☐	2☐	3☐
5 Lying down to rest in the afternoon?	0☐	1☐	2☐	3☐
6 Sitting and talking to someone?	0☐	1☐	2☐	3☐
7 Sitting quietly after lunch without alcohol?	0☐	1☐	2☐	3☐
8 In a car, while stopped for a few minutes at a traffic light?	0☐	1☐	2☐	3☐
(sum of all numbers checked above) Total Score				

CPAP:
Are you currently using CPAP? ☐ YES ☐ NO ☐ If yes, for how long? _____

Phone Number: 1-877-753-3776