RM _____

PAID _____

THE FLYING DOC INC.

We'll Keep You Flying!

MedXPress # _____

ECG TODAY

☐ **Yes** ☐ **No**

Date of last ECG:

_____

DEMOGRAPHICS and H&P

Date: _____

☐ **New Patient** ☐ **Returning Patient**

☐ **Pre-Flight Physical** ☐ **1st Class** ☐ **2nd Class** ☐ **3rd Class** ☐ **Special Issuance Certificate**

Patient Information

Name: _____ Date of Birth: _____ Age: ____ Gender: _____

Phone: _____ Email Address: _____

Address: _____

Ethnicity: _____ Social Security #: _____

Corrective Lenses: ☐ Yes ☐ No Hearing Aid: ☐ Yes ☐ No

→ Please list all tattoos and scars: _____

_____

→ Please acknowledge that all the information you have provided is true and correct to the best of your knowledge.

_____ _____

Signature Date

HIPAA Privacy Notice

I hereby acknowledge that a written Notice of Privacy Practice is available upon request and posted for me to review. The Privacy Notice provides a complete description of how my health information may be used or disclosed. I understand that I have the right to review the practice notice prior to signing this consent. I understand that The Flying Doc, Inc. will use and share my health information with the Federal Aviation Administration in compliance with FAA requirements. I understand that The Flying Doc, Inc. reserves the right to change their notice and information practices. I may obtain a copy of the revision by written request to The Flying Doc's Medical Records Department at 11764 SE Dixie HWY, Unit 6, Hobe Sound, FL 33455. I understand that I have the right to restrict how the Flying Doc uses or discloses my protected health information to carry out treatment, receive payment and conduct healthcare operations. The Flying Doc, Inc. is not required to agree to the restriction. The Flying Doc, Inc. is bound by restrictions to which it agrees.

→_____ _____ _____/_____/_____

Print Name Signature Date

FOR OFFICE USE

Vitals:

B/P: _____ /_____ O2: _____ Pulse: _____ Temp: _____ Weight: _____ Height: _____

List of Current Medications

(use reverse side for additional space)

Medication Name	Dose/MG	How often

REVIEW OF SYSTEMS

		YES	NO
1.	GENERAL:		
	Do you usually feel persistently tired or worn out?	_____	_____
	Have you recently been drinking more water or fluids?	_____	_____
	Has there been any unusual weight gain or loss recently?	_____	_____
2.	CARDIOVASCULAR:		
	Do you have pain, tightness, or pressure in the front or back of your chest?	_____	_____
	Do you have any swelling of your feet or ankles?	_____	_____
	Do your fingers or toes ever get cold, become numb, or get very white or bluish?	_____	_____
3.	CENTRAL NERVOUS SYSTEM:		
	Do you have frequent or severe headaches?	_____	_____
	Do you have spells of dizziness, faintness, or lightheadedness?	_____	_____
4.	EYES/ENT:		
	Have you had any pain in your eyes or blurry vision or had a change in your vision?	_____	_____
	Have you had cataracts or implants?	_____	_____
	When did you last see an eye doctor? _____		
	Do you have any trouble hearing or any ringing or buzzing in your ears?	_____	_____
5.	GASTROLINTESTINAL:		
	Do you have a lot of indigestion or heartburn?	_____	_____
	Are you bothered by constipation or frequent loose stools or diarrhea?	_____	_____
6.	SKIN:		
	Do you have any rashes or itching, or any growths or lumps that do not heal?	_____	_____
7.	GENITOURINARY:		
	Do you have trouble when you urinate?	_____	_____
	Do you have to urinate frequently? At night?	_____	_____
	Have you ever had an operation to prevent pregnancy? (Such as: Vasectomy or Tubal Ligation)	_____	_____
8.	MUSCULOSKELETAL:		
	Do you have a chronic problem with back pain?	_____	_____
	Do you have chronic joint pain or stiffness (Arthritis)?	_____	_____
	Do you have trouble walking or using your hip or knee joints?	_____	_____
	Do you have numbness or tingling in your arms or legs?	_____	_____
9.	RESPIRATORY:		
	Do you have a constant or bothersome cough?	_____	_____
	Do you have difficulty breathing at rest or with exercise?	_____	_____
	Do you have a history of a positive reaction to a tuberculosis (TB) skin test?	_____	_____
10.	PSYCHIATRIC:		
	Do you have feelings of depression, anxiety, nervousness, or tenseness?	_____	_____
	Do you have problems with memory?	_____	_____
	Do you have trouble sleeping?	_____	_____
11.	ENDOCRINE:		
	Do you have heat or cold intolerance?	_____	_____
	Do you have excessive sweating, thirst, or hunger?	_____	_____
12.	HERMATOLOGIC/ANEMIA:		
	Do you bruise or bleed easily?	_____	_____
13.	MEN ONLY:		
	Do you have prostate gland trouble?	_____	_____
14.	WOMEN ONLY:		
	Was your most recent period normal?	_____	_____
	Was your last mammogram normal?	_____	_____
	Pregnancies?		
	Premature _____ Full Term _____ Abortions_____ Miscarriages_____		
	Do you know how to examine your breasts?	_____	_____
	Do you have any lumps in your breasts or discharge from your nipple?	_____	_____

TOBACCO USE ASSESSMENT AND CESSATION INTERVENTION:

	YES	NO
Do you currently smoke or chew tobacco?	_____	_____
If Yes:		
Do you wish assistance on quitting?	_____	_____

AUDIT-C (Alcohol Use Disorders Identification Test) *(M>=4, F>=3)*

How often do you have a drink containing alcohol? Never | Monthly or less | 2-3 times a week | 4 or more times a week | 2-4 times a month

How many standard drinks containing alcohol do you have on a typical day? 1-2 | 3-4 | 5-6 | 7-9 | 10 or more

How often do you have six or more drinks on one occasion? Daily/almost daily | Weekly | Less than monthly | Monthly | Never

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems:

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: Total Score ___ = ___ + ___ + ___)