

Patient Information Sheet:

Patient Name _____ Date of Birth _____

Mailing Address: _____

City _____ State _____ Zip _____

Phone# (H) _____ SS# _____

Patient's Employer _____ Phone# _____

Emergency Contact _____ Relation _____

Address _____ Phone# _____

Spouse's or Parent's Name _____ D.O.B _____

Employer _____ Phone# _____

Primary Insurance Company _____ Name of Policy Holder _____

SS# of Policy Holder _____ D.O.B of Policy Holder __/__/____

Local Visiting Address & Phone _____

I hereby Authorize the office of Primary Medical Associates to release information that may be necessary for verifying insurance coverage, per certification, claim filing and referral treatment to another facility.

I understand the fees are due and payable at the time of service unless prior arrangements are made. This includes deductibles, co-pays and self pay. I hereby Authorize payment of medical benefits to the Physicians rendering services. I understand that I am financially responsible for charges not covered by my insurance.

I voluntarily consent to participate in treatment and understand that I will be kept informed of plans for my treatment and may withdraw this consent at any time with written notice. I also acknowledge that I have received the Notice of Privacy Practices.

Signed _____

Date _____

James M. Vest, MD
Fritz Frye, PA
Alicia Anderson, NP

4022 Postal Way
Myrtle Beach, SC 29579
843 236-0000

Patients Name: _____

Phone Number: _____

Can a message concerning your medical condition be left on an answering machine? YES___ NO___

Can a message concerning your medical condition be left on your cell phone voice mail? YES___ NO___

Cell Phone Number: _____

Who can a message concerning your medical condition be left with?

Name: _____ or No One _____

Can we call your work number? YES___ NO___

Work Number: _____

Patients Signature: _____

Date: _____

PMA Employee Witness: _____

Date: _____

Yearly Required Health Risk Assessment

Physical Activity

How many days of the week do you usually exercise
_____ days per week

On days when you exercise, for how long do you usually exercise?

_____ minutes per day
_____ does not apply

How intense is your typical exercise (check one)

_____ Light (stretching or slow walking)
_____ Moderate (brisk walking)
_____ Heavy (jogging or swimming)
_____ Very heavy (fast running or stair climbing)
_____ I am not currently exercising

Smoking / Tobacco Use

Do you currently smoke cigarettes or use other types of tobacco (check one)

_____ Yes
_____ No

Are you a former smoker?

_____ Yes
_____ No, I've never smoked

If you quit smoking, how long ago did you quite smoking cigarettes?

_____ Less than 6 months ago
_____ 1-5 years ago
_____ 6-10 years ago
_____ More than 10 years ago
_____ Does no apply

Do you use these other tobacco products? Check all that apply:

_____ Cigars
_____ Pipes
_____ Chewing tobacco / snuff
_____ I use no other tobacco products

Alcohol Use

In a typical week, how many days do you drink alcohol?

_____ days per week.

On days when you drink alcohol, how many alcoholic drinks do you consume?

_____ drinks per day.

In a typical week, how often do you have 5 or more alcoholic drinks on one occasion?

_____ never

_____ once a week

_____ 2-3 times per week

_____ more than three times per week

Nutrition

On a typical day, how many servings of fruits and/or vegetables do you eat (1 serving equals 1 cup of fresh vegetables, a 1/2 cup of cooked vegetables or one medium piece of fruit. One cup is about the size of a baseball.

_____ servings per day

On a typical day how many servings of high fiber or whole grain foods do you eat? One serving equals one slice of 100% whole grain bread, One cup of grain or high fiber cereal, 1/2 cup of cooked cereal (oatmeal) or 1/2 cup of cooked brown rice or whole wheat pasta.

_____ servings per day

On a typical day, how many servings of fried or high fat foods do you eat? Examples: fried chicken, fried fish, bacon/pork, french fries, potato chips, corn chips, doughnuts, creamy salad dressings, foods made with whole milk, cream, cheese or mayonnaise.

_____ servings per day

Motor Vehicle Safety

Do you always fasten your seat belt when you are in the car?

_____ yes

_____ no

Do you ever drive after drinking or ride with a driver who has been drinking?

_____ yes

_____ no

Sun Exposure

Do you protect yourself from the sun when you are outdoors?

_____ yes

_____ no

Blood Pressure

If your blood pressure was checked within the past year, what was the result?

- low or normal (at or below 120/80)
- borderline high (120/80 to 139/89)
- high (140/90 or higher)
- do not know
- does not apply

Cholesterol

If your cholesterol was checked within the past year, what were your total cholesterol results?

- desirable (below 200)
- borderline high (200-239)
- high (240 or higher)
- do not know
- does not apply

Blood Glucose

If your glucose (sugar) was checked within the past year, what was the results of your fasting glucose level?

- desirable (below 100)
- borderline high (100-125)
- high (126 or higher)
- do not know
- does not apply

Have you ever been told by a doctor or health professional that you have diabetes or high blood sugar?

- yes
- no

If you have had your hemoglobin A-1-C checked within the past year, what was the result?

- desirable (6 or lower)
- borderline high (7)
- high (8 or higher)
- do not know
- does not apply

Height / Weight

What is your height?

_____ feet _____ inches

What is your weight?

_____ pounds

Depression

Over the past two weeks, have you felt down, depressed or hopeless?

_____ almost all the time

_____ most of the time

_____ some of the time

_____ almost never

Over the past two weeks, have you felt a lack of interest or pleasure in doing things?

_____ almost all the time

_____ most of the time

_____ some of the time

_____ almost never

Have your feelings caused you distress or have they interfered with your ability to interact socially with friends?

_____ yes

_____ no

During the past six months how often have you felt depressed or sad?

_____ almost all the time

_____ most of the time

_____ some of the time

_____ almost never

In general, how satisfied are you with your life?

_____ very satisfied

_____ satisfied

_____ dissatisfied

_____ very dissatisfied

High Stress

How often is stress a problem for you?

- never / rarely
- sometimes
- often
- always

How well do you handle the stress in your life?

- I am usually able to cope effectively
- at times I have problems coping
- I often have problems coping

General Well-Being

In general, would you say your health is:

- excellent
- very good
- fair
- poor

Social Emotional Support

How often do you get the social and emotional support you need?

- always
- usually
- sometimes
- rarely
- never

General Life Satisfaction

In general, how satisfied are you with your life?

- very satisfied
- satisfied
- dissatisfied
- very dissatisfied

Sleep

how many hours of sleep do you usually get each night?

Daily Aspirin Use

Have you discussed taking a daily aspirin with your doctor?

_____ yes

_____ no

Medical History

Have you ever had any major illness or accident that caused you to be hospitalized?

_____ yes

_____ no

If yes, describe the incident:

List any surgeries you have had (include any removals: tonsils, spleen)

List any doctors, nurse practitioners or physician assistant that you currently see.

Have you had a bone mineral density screening?

_____ yes _____ year

_____ no

Have you had a colonoscopy?

_____ yes _____ year

_____ no

FAMILY HISTORY

MEDICAL PROBLEMS	Father	Mother	Father's Parents	Mother's Parents	Brothers / Sisters	Children
Heart Disease						
High Blood Pressure						
Stroke TIA						
Cancer						
Seizures						
Diabetes						
Liver Disease						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Sickle Cell						
Bleeding Disorders						

=====

MEDICAL HISTORY (Please Check if you have a history of the following)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Headache | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bowel irregularity | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bladder/urinary | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Allergies/Hay fever | |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Vascular disease | <input type="checkbox"/> AIDS | |
| <input type="checkbox"/> Hepatitis/Liver | <input type="checkbox"/> Anemia | |

List any medication reactions or allergies:

Have you ever been tested for glaucoma?

_____ yes _____ year _____ eye doctors name
_____ no

Females Only:

When was you last mammogram?

_____ (mm/dd/yy)

_____ number of pregnancies

_____ number of deliveries

_____ last menstrual period

Males Only:

When was your last prostate exam?

_____ (mm/dd/yy)

Have you ever had the pneumonia vaccine?

_____ yes _____ year or age

_____ no

If you are over 50 have you had the shingles vaccine

_____ yes _____ year or age

_____ no

Advanced Care Planning

Do you have a Living Will?

_____ yes

_____ no

_____ do not know what it is

Have you appointed anyone as your healthcare power of attorney?

_____ yes

_____ no

_____ do not know

Would you like information on completing Advanced Directives such as a Living Will or health care power of attorney?

_____ yes

_____ no