Matthews-Vu
Healthcare for Children and Adults

Dear Patient or Legal Guardian:

Our records indicate that you have been scheduled today for a "Routine Physical Examination' and/or a "Well Woman Examination'.

This service will be coded by our office as a 'Routine Physical Examination or a 'Well Woman Examination'. Your insurance company benefits MAY NOT cover this exam. Your particular plan must have preventative benefits for this exam to be covered.

This type of examination is strictly a comprehensive preventative medical examination. Please be aware that any abnormality encountered or preexisting problem that needs addressed, will be billed separately and could require an additional copay or coinsurance amount from you.

If it is determined by our healthcare provider that Lab Work is necessary, please inform the phlebotomist what lab your insurance company prefers to use. Please note that the lab that processes the specimens will bill your insurance company separately for all labs done by them. These lab services MAY NOT be covered by your insurance plan as part of your 'Routine Physical Examination or 'Well Woman Examination'.

It is your responsibility to know if you have coverage for wellness, preventative, well woman or health screening benefits. All services for today's visit, whether billed by this office or the reference laboratory, not paid by insurance, are your financial responsibility.

The healthcare providers of Matthews-Vu Medical Group believe that a periodic, routine physical examination with certain diagnostic labs or other age-appropriate procedures, are an integral part of providing excellent patient healthcare.

By signing below, you acknowledge and accept financial responsibility for all charges not paid by your insurance company associated with your visit today.

Thank you –

Date of Physical Exam _____ Account #:_____

Patient Name (Printed) _____ Date of Birth _____

Signature of Patient or Legal Guardian _____

Annual Wellness Questionnaire

Patient Name:_____ Date of Birth:_____ Visit Date: _____

Please fill out the following information regarding your health:

General Health

In general, would you say your health is

Excellent Very Good Good Fair Poor

How would you describe the condition of your mouth and teeth?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

In the past 7 days, how much pain have you felt?

None Some A lot

Nutrition

In the past 7 days, did you eat fruits or vegetables each day?

Yes No

In the past 7 days, did you eat whole grain or high fiber foods each day?

Yes No

In the past 7 days, did you eat fried or high fat foods each day?

Yes No

In the past 7 days, how many sugar-sweetened beverages did you consume each day?

0 1-2 3-4 5 or more

Social/Emotional

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

Almost all of the time Most of the time Some of the time Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worry?

☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

How often is stress a problem for you in handling your health, finances, family or social relationships, or your work?

Never or Rarely Sometimes Often Always

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

Always Usually Sometimes Rarely Never

Patient Name:_____ Date of Birth:_____ Visit Date: _____

Activities of Daily Living and Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?

Yes No

In the past 7 days, did you need help from others to care for things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

Yes No

Seat Belt

Do you fasten your seat belt when you are in a car?

☐ Yes ☐ No

Sleep

Each night, how many hours of sleep do you usually get?

_____ hours

Do you snore or has anyone told you that you snore?

Yes No

In the past 7 days, how often have you felt sleepy during the daytime?

Always Usually Sometimes Rarely Never

Vision

Have you seen your eye doctor within the last 12 months?

Yes No – If **no**, please schedule an appointment with your eye doctor as soon as possible

Please list any **DME** (durable medical equipment) companies you are currently using (Examples: Elevation Medical Supply, Apria, Major Medical, Advanced Medical):_____