PREVENTIVE CARE EXAM

WIMBERLEY MEDICAL CLINIC
Growing families the healthy way

Please be advised that your **preventive care exam** (aka “annual exam”, “physical exam”, “well women exam”, etc.) is a specific service designed to screen for and prevent health issues. It may include a clinical examination, laboratory tests, counseling, and/or immunizations depending on your age, gender, and other risk factors.

In most cases, the preventive care exam is free to you. The Affordable Care Act obligates most insurance plans to pay for this service without charging you a copayment, coinsurance, or deductible.

However, there are important exceptions to this rule -

NEW OR EXISTING HEALTH ISSUES

The evaluation and management of new or existing health issues is not covered under the preventive care exam. Insurance providers regard these issues as separate and distinct from the preventive care exam. Thus, the evaluation and management of new or existing health issues during the preventive care exam will generate charges that will be your responsibility (including but not limited to copayment, coinsurance, and deductible).

Please note that a **medication refill** falls in the category of an **existing health issue.**

I have read the information above. I understand that the evaluation and management of new or existing health issues is not covered under the preventive care exam. I understand that the evaluation and management of new or existing health issues during the preventive care exam will generate charges (including but not limited to copayment) that will be my responsibility.

Name: _____ Signature: _____ Date: _____

Your appointment is scheduled on: _____ Time: _____ Provider: _____

Please remember to fast before your appointment, nothing to eat after midnight the night before. Only water the morning of your exam. ***Please complete the form attached and bring it with you.***

WMC - PATIENT HISTORY FORM

Patient Name: _____ Date _____

Date of Birth:_____ Gender: Male / Female

Patient History: Please indicate if **YOU** have any of the following:

Illness / Diagnosis	Date Diagnosed:	Illness/Diagnosis	Date Diagnosed:
Aids/HIV		Hepatitis (A, B, C, D)	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Alcoholism		Liver Disease	
Allergies		Lung Disease	
Arthritis (RA or Osteo)		Fibromyalgia	
Asthma		Headaches/Migraines	
Cancer (what kind)		Measles/Mumps	
Drug Dependency		Pneumonia	
Chicken Pox		Psychiatric Care	
COPD/Emphysema		Rheumatic Fever	
Depression		STDs (what kind)	
Diabetes (I or II)		Stomach Ulcers	
Bladder/Kidney disease		Stroke	
Seizures		Thyroid Problems	
Eye Conditions		Gout	
Heart Disease		Tuberculosis	
Prostate Problems		Chronic Pain (why)	
Skin Problems		Eating Disorder	
ADD/ADHD		**OTHER:**	

DRUG Allergies: _____

Surgical/Hospitalization History:

Example: Hernia repair	2003	CTMC	Dr. Jane Doe

Patient Name_____ Date:_____

Preventative Care History:

Exam/Screen	Date	Exam/Screen	Date
Cholesterol		Flu Vaccine	
Eye exam		Pneumonia Vaccine	
Hearing Test		Shingles Vaccine	
TB skin test		Hepatitis Vaccines	
Colonoscopy			
Results of Colonoscopy			
Females:			
Mammogram		PAP smear (any abnormal?)	
Clinical Breast Exam		Bone Density Scan	
Last Menstrual Cycle		Age at first menses	
Regular periods?		Birth Control Method	
# of Pregnancies		# of Living children	
Complications of any pregnancies:			
Males:			
Prostate Exam		PSA blood test	

Social History: Please indicate if you use or have used any of the following:

Alcohol : Yes No	Drinks/ week:	How Long:	When stopped:
Caffeine: Yes No	Ounces /day:		When stopped:
Tobacco: Yes No	Type:	Amount /day:	When stopped:
Street Drugs: Yes No	Type:	How Long:	When stopped:

Sexual History:

Sexually Active? Yes No	Male or Female Partners, or Both?	# partners in last year:
Any Concern for STDs? Yes NO		

Patient Name_____ Date _____

Family History: Please indicate if any of your relatives have any of the following:

Illness	Relation	Illness	Relation
Aids/HIV		Hepatitis (A, B, C, D)	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Alcoholism		Liver Disease	
Allergies		Lung Disease	
Arthritis (RA or Osteo)		Fibromyalgia	
Asthma		Headaches/Migraines	
Drug Dependency		Pneumonia	
COPD/Emphysema		Psychiatric Care	
Depression		Rheumatic Fever	
Diabetes (I or II)		Stroke	
Bladder/Kidney disease		Thyroid Problems	
Seizures		Gout	
Eye Conditions		Tuberculosis	
Heart Disease		CANCER: **(what type)**	
Prostate Problems			
OTHER:			

Any other Significant Illnesses, Injuries or Information about you:

_____

_____

_____

_____

Patient Name: _____ Date:_____

Medications and/or Supplements that you are currently taking:

(Please include OTC meds as well)

RX name	Dose:	How often?	Prescriber:	Pharmacy filled at:
Example: Lisinopril	20mg	Once /day	Dr. Jane Doe	Walgreens

Please list any other medical providers you are under the care of:

Example: Dr. Jane Doe	Cardiologist