JAMISON
FAMILY MEDICINE
COMPLETE HEALTH & WELLNESS

9631 N Nevada St. Suite 210

Spokane, WA 99218

Phone: (509) 319-2430 and Fax: (877)568-2402

Jeffrey R. Jamison, D.O. and Mark J Erwin, PA-C

You are scheduled for a medical examination with _____ on _____. The following instructions will help assure accurate results.

1. Please allow 1 hour for your appointment. You will have any necessary lab work done which may include an EKG and/or chest x-ray.
2. **No alcohol** for 72 hours before your appointment.
3. Do not have anything by mouth after 7pm the night before your appointment. This includes mints and gum. **You can drink water.**
4. If you are on medications, please take them as prescribed. If food is required, eat a small amount.
5. Women: do not douche for 72 hours before your exam.
6. Please complete the enclosed personal history form and bring it in with you.
7. If you have any questions regarding these instructions, please feel free to call our office. **If you are unable to keep your appointment, please provide 24 hours' notice.**

Please note: Your Annual Physical Examination will be a health review and will concentrate on preventative medicine. Please schedule a separate appointment for specific conditions or illness concerns you may have.

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PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

PATIENT PERSONAL HISTORY FORM

Name: _____ Age: _____ Date: _____

Birth Date: _____ Place of Birth: _____

Occupation: _____

Doctor: _____

Date of last physical exam: _____

List all states and countries you have lived: _____

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Dear Patient,

You have requested an annual physical appointment with your doctor.

An annual physical can range from $300-$500 depending on the number of tests run. Most insurances will allow an annual physical exam. The benefits may be limited on what your plan may cover.

A routine wellness physical (annual physical) is an examination that may include an array of lab tests, chest x-ray, and EKG to test current medical conditions, as well as to screen for undetected problems. Wellness physicals are not diagnostic exams.

Please contact your insurance company prior to your appointment to check your benefits for this exam as well as any limitations that may apply to lab testing.

Please note the front desk cannot contact your insurance and are not able to determine the cost of your visit or what your insurance plan will allow.

It is important for **you** to understand your benefits in order to request the appropriate service from your provider. Once a service has been rendered, it is fraudulent for us to change the chart note in order to support a change in charges. Therefore, we **WILL NOT** change and re-bill charges once they are rendered.

Review of Systems

Allergic/Immunologic

- Frequent Sneezing
- Hives
- Itching
- Runny Nose
- Sinus Pressure

Cardiovascular

- Arm pain on exertion
- Chest pain on exertion
- Chest Heaviness/ Pressure on exertion
- Irregular Heartbeats (Palpitations)
- Known Heart Murmur
- Light headed on standing
- Shortness of breath when lying down
- Shortness of breath with walking
- Swelling (edema)

Constitutional

- Exercise intolerance
- Fatigue
- Fever
- Weight Gain (___ lbs)
- Weight Loss (___lbs)

Endocrine

- Fatigue
- Increased Thirst/ Hunger/Urination
- Difficulty getting pregnant

Eyes

- Dry eyes
- Irritation
- Vision Change
- Date of last exam _____

Ears/Nose/Mouth/Throat

- Bleeding gums
- Difficulty hearing
- Dizziness
- Dry Mouth
- Ear Pain
- Frequent colds/ sinus infections
- Frequent infections
- Frequent nosebleeds
- Hoarseness
- Mouth Breathing
- Mouth Ulcers
- Nose/Sinus Problems
- Ringing in ears
- Cough
- Coughing up blood
- Shortness of breath
- Sleep Apnea
- Snoring
- Wheezing

Respiratory

- Cough
- Coughing up blood
- Shortness of breath
- Sleep Apnea
- Snoring
- Wheezing

Gastrointestinal

- Abdominal pain
- Black or tarry stool
- Blood in stool
- Change in appetite
- Frequent indigestion
- Hemorrhoids
- Trouble swallowing
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Difficulty Urinating

- Incomplete emptying
- Increased urinary frequency
- Urinary loss of control
- Erectile dysfunction

Hematologic/Lymphatic

- Easy Bruising
- Swollen glands
- Anemia

Integumentary (skin)

- Changes in moles
- Dry skin
- Eczema
- Growth/lesions
- Itching
- Jaundice (yellowing of skin/eyes)
- Rash

Neurological

- Dizziness
- Fainting
- Headaches
- Memory loss
- Migraines
- Numbness
- Restless legs
- Seizures
- Weakness

Psychiatric

- Alcohol over use
- Anxiety/stress
- Depression
- Do not feel safe in relationship
- Mania
- Sleep Problems
- History of Addiction

PATIENT NAME _____ Date of birth _____

Past Surgical History (Please include year, reason and what hospital and/or Doctor if you are able.):

_____

_____

_____

_____

_____

Family History: Please place a check in the boxes appropriate for your family history.

Relation	Grandmother (M)	Grandfather (M)	Grandmother (P)	Grandfather (P)	Mother	Father	Brother	Sister	Other
Alive?									
Age									
Alcoholism									
Arthritis									
Depression									
Cancer/type									
Diabetes									
Genetic disease									
Heart disease									
Hypertension									
Osteoporosis									
Stroke									
Other									

Immunization History: Please indicate Y/N for immunizations you were given and when. If unknown, which facility would have them on file?

Chicken Pox:	Date:	MMR (Measles, Mumps, Rubella):	Date:
Flu Shot:	Date:	Pneumonia:	Date:
Gardasil/HPV:	Date:	Tdap(Tetanus, diphtheria, pertussis):	Date:
Hepatitis A:	Date:	Tetanus:	Date:
Hepatits B:	Date:	Zostavax/Shingles:	Date:
Meningococcus:	Date:	Other:	Date:

(Women Only) Obstetric and Gynecological History:

Last pap smear:		Last mammogram:	
Age of first period:		Number of births:	
Number of pregnancies:		Number of miscarriages:	
Last period/Age of Menopause:		Number of cesarean sections:	

Number of abortions:		Current sexual partner:	Male or Female
Do you use condoms?	Y / N	Method of Birth Control:	
Interested in STD screen?	Y / N		

(Women Only) Circle any of the following that apply to you:

Bleeding between periods	Heavy Periods	Extreme Menstrual Pain	Vaginal itching, burning or discharge	Waking up in the night to use the restroom
Hot Flashes	Breast lump or nipple discharge	Painful intercourse	Sexually Active	Other

Past Medical History: Circle any of the following that apply to you:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobia	HIV or AIDS	Reflux or Ulcers

Diabetes- Insulin	High Cholesterol	Stroke
Diabetes – Non Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

Social History: Circle the following that apply to you:

Education	**Marital Status**	**Exercise**	**Caffeine**
○ <8th grade ○ High School ○ 2 Yr college ○ 4 Yr college ○ Post Graduate	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Domestic Partner	○ No Exercise ○ Occasional Exercise ○ Moderate Exercise ○ High Level Exercise	○ None ○ Occasional ○ Moderate ○ Heavy _____ # of cups per day?

Alcohol	**Tobacco**	**Drugs**
Drink alcohol? Y / N How often? ○ Occasionally ○ < 3 times a week ○ > 3 times a week # of drinks/ week? _____	Do you use tobacco? Y / N If not now, did you ever use tobacco? Y / N ○ Cigarettes _____ pks/day ○ Chew _____/day ○ Cigars _____/day # years used _____ Or years quit_____	Do you currently use recreational or street drugs? Y / N If yes, please list which ones:

PATIENT NAME:_____ Date of Birth: _____

Additional Health facts: (Please list other information about your health you would like your Provider to know):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient, Parent, Guardian or Caregiver Signature Date