AURORA FAMILY PRACTICE GROUP, P.C.

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PLEASE READ

Dear Patient,

We look forward to seeing you for your *Complete Physical Examination.* **IF IT IS NECESSARY TO CANCEL YOUR APPOINTMENT, WE DO REQUIRE A 48-HOUR NOTICE. OTHERWISE WE RESERVE THE RIGHT TO CHARGE $100.00.** *** ***KEEP IN MIND***; Weekends *are included* in the 48-hour notice requirement. Our after-hours answering service can certainly take your message, we should receive it Monday morning.

The complete physical exam will include a diagnostic profile, which is a battery of blood tests evaluating cholesterol, glucose (sugar), kidney function, liver function, thyroid function, and complete blood count. The physical may also include a urinalysis (collected in office), electrocardiogram (EKG), spirometry (breathing test), hemoccult (stool sample for colon cancer screening), pap smear, and/or any other tests as individually indicated. The physician will then perform a comprehensive exam and discuss the results as they become available.

The enclosed forms are *part* of your *complete physical exam* that you have scheduled. Please have these forms *completely* filled out and bring the day of your appointment. This information is for comprehensive review of your current health status. This examination involves a large amount of our time and yours. We would like to suggest the following to make sure this endeavor is as efficient as possible.

A ***PHYSICAL*** covers a comprehensive exam and preventive issues. If we spend part of your appointment time addressing new or chronic *non-preventive issues*, such as medication refills, insomnia, reflux, chest pain, or re-evaluating a chronic issue such as hypertension, etc. These issues will be submitted to your insurance company and that may incur a co-pay, deductible, or co-insurance that is *separate* from your physical, depending on your insurance benefits.

Most insurance carriers consider a complete physical exam a preventive service. You must verify that your insurance carrier covers this type of service before coming in, as well as the frequency of the service covered, *if* covered. Our office must bill your insurance carrier a preventive code with a diagnosis of "*physical exam*". **We understand that some carriers might not cover these services, so it is important for you to know your insurance benefits.** Please do not ask our office to change a diagnosis code so that your insurance carrier will pay your claim. *It is against the law to alter or change any information other than what is originally submitted on your claim.* You will be financially responsible for any services denied by your carrier.

We try to allow enough time at our physical exam appointments to discuss such issues. This is done to allow more complete care and make it more convenient for our patients. Many of our patients are busy and 'try to get it all done in one day', we definitely understand. We do have to bill insurance and charge for these non-preventive issues just as we would if you made a separate appointment for such issue. We know many of our patients are finding it more difficult financially and we can relate. Family Practice and Primary Care are under severe financial pressure from insurance companies and the government. The overhead in primary care is extremely high because we have to manage every patients' labs, ER reports, specialists' notes, employer forms, medication refills, phone calls, etc. We are just trying our best to provide excellent medical care to our patients and still survive in such an environment. We appreciate your understanding and compliance and as always, we value our relationship with you.

1550 S. Potomac St, Suite 370 Aurora, Colorado 80012-5454 Phone: (303)369-1080 Fax: (303)370-4913

OVER

There are *three* things that must be completed prior to your visit. First, fill out the enclosed history form. This provides the physician with a comprehensive view of your family history. It is an important and necessary tool in your exam. Second, is the hemoccult test. This is the colon cancer-screening device to ascertain if there is blood in the stool (instructions are on the inside of the card). Bring the completed card with you to your exam. Third, is your blood work. A lab requisition will be either, included with these forms or given separately. Please take the enclosed lab requisition form to the designated lab to have your blood work done 5-7 days ***prior*** to your physical appointment. *(If no lab slip was given, may be due to previous blood work done in the last 6 months. Insurance won't cover)*

Please ***do not*** wear body lotion the day of your appointment.

Please bring a *current* list of all medications you are taking including supplements or vitamins.

Thank you,

The physicians of Aurora Family Practice Group, P.C.

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Name _____ Date _____

WELL-WOMAN EXAM

To help your doctor during today's health exam, complete articles 1 through 11.

1. Age _____

   First day of last menstrual period (or first year of menstruation, if through menopause): _____

2. Number of pregnancies: _____

   Number of pregnancies completed: _____

   Date of Last Pregnancy: _____

   If you are under 55, what method of birth control use? _____

   If pills, what kind? _____

   How many years have you used the pills? _____

   Are you planning a pregnancy in the next 6-12 months? O YES O NO

3. If you are through menopause or over the age of 50, do you take any of the following pills?

Calcium	O YES	O NO
Estrogen (Premarin)	O YES	O NO
Progesterone (Provera)	O YES	O NO

4. Have you had any of the following problems:

   a) Abnormal Pap smear O YES O NO

      If yes, date _____ Problem _____

      For abnormality, did you have any of the following done:

Colposcopy	O YES	O NO
Biopsy	O YES	O NO
Surgery	O YES	O NO

   b) High blood pressure, heart disease, or high cholesterol O YES O NO

   c) Migraine headaches, blood clot in legs or cancer O YES O NO

   d) Abdominal or pelvic surgery or special tests O YES O NO

      In case, what? _____ When? _____

5. Do you have one of the following:

   a) Problems with the current method of birth control O YES O NO

   b) Bleeding between periods or since periods stopped O YES O NO

   c) Pain with intercourse or periods O YES O NO

   d) Any problems with interest in or enjoying intercourse O YES O NO

   e) A new or enlarged lump in breast O YES O NO

   f) Change in size/firmness of stools O YES O NO

   g) Change in size/color of mole O YES O NO

   h) Severe headaches O YES O NO

   i) Pain in the leg(s), chest, abdomen or joints O YES O NO

   j) Trouble falling or staying asleep O YES O NO

   k) Often feeling down, depressed or hopeless during the past month O YES O NO

   l) Often having little interest or pleasure in doing things during the past month O YES O NO

   m) Conflict in family or relationships, sometimes handled by pushing, hitting, or cruelty O YES O NO

6. Do you have a parent, or sibling with a history of the following:

   a) Cancer of the breast, intestine, or female organs O YES O NO

   b) Heart pain or heart attacks before the age of 55 O YES O NO

   If yes to a or b:

   Relation _____ Type _____

   Relation _____ Type _____

7. Osteoporosis (thin bone) screening:

   a) Is there a history of any relatives with the following: O YES O NO

      Stooping over or losing height as they got older, "thin bones," hip fractures

      If so, relation: _____

   b) Have you had one of the following:

Height loss	O YES	O NO
Broken hip or wrist	O YES	O NO
Bone-Density test	O YES	O NO

   c) Do you take any of the following:

Steroids (Prednisone)	O YES	O NO
Thyroid medications	O YES	O NO
Seizures or thin bones	O YES	O NO

8. Have you ever used tobacco? O YES O NO

   If yes:

   Average number of packs/day: _____

   Number of years Smoked: _____

   Year Quit: _____

   When do you plan to quit smoking?

   O Now O Next 6 Months O Someday O Never

Form continues on next page ●

9. Do you drink alcohol? O YES O NO

If yes:

a) Have you ever felt you should reduce on your drinking? O YES O NO

b) Have people ever bothered you by nagging about your drinking? O YES O NO

c) Have you ever felt guilty about your drinking? O YES O NO

d) Have you ever had a drink first thing in the morning to stabilize your nerves or get rid of a hangover? O YES O NO

10. Prevention:

a) Which of the following are included in your diet:

Grains and Starches	O A Lot	O Some	O Few
Vegetables	O A Lot	O Some	O Few
Dairy foods	O A Lot	O Some	O Few
Meats	O A Lot	O Some	O Few
Sweets	O A Lot	O Some	O Few

b) Exercise:

Activity _____

Days per week _____

Time/Duration _____ Minutes

Effort/Exertion:

c) Do you always wear seat belts? O YES O NO

d) If over 30 years old, have you had your cholesterol levels in the last five years? O YES O NO O N/A

e) Have you had a tetanus shot in the last 10 years? O YES O NO

f) Do you have a working smoke detector at home? O YES O NO

g) Do you have firearms/guns at home? O YES O NO

h) Have you ever had a mammogram? O YES O NO

If yes, date of last: _____Where_____

Have you ever had any abnormal mammogram? O YES O NO O N/A

If yes, date_____Problem_____

For abnormality, did you have any of the following:

Biopsy	O YES	O NO
Cyst Fluid Drained	O YES	O NO
Surgery	O YES	O NO

i) How many sexual partners have you had in the last 12 months?_____ In your life?_____

j) When was the last time you had a dental check-up?

_____

11. SCOFF Assessment Tool

a) Do you make yourself sick to the point where you feel uncomfortable full? O YES O NO

b) Do you worry that you may have lost control over how much you eat? O YES O NO

c) Have you recently lost more than 14lbs in a 3-month period? O YES O NO

d) Do you believe yourself to be "fat" when others are "too thin"? O YES O NO

e) Would you say that food dominates your life? O YES O NO

Thank you for your help!

Sleep Disorder Symptoms Assessment

Name:_____

Date of Birth: (M/D/Y) ____/____/____ Gender: M____ F____

FOR OFFICE USE:
Height: _____
Weight: _____
BMI: _____
Neck Size: _____
Blood Pressure: _____

Please check any of the following you may have:

☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night (Nocturia)	☐ Diabetes	☐ Depression	☐ Overweight

Snoring:		Score
1. Do you snore often (3 or more nights a week)?	☐ YES ☐ NO ☐ Don't Know	____ Yes = 1
2. Is your snoring loud enough to be heard through a closed door or annoy other people?	☐ YES ☐ NO ☐ Don't Know	____ Yes = 1
3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air?	☐ YES ☐ NO ☐ Don't Know	____ Yes = 2
	(sum of all numbers checked above) Total Score	

Epworth Sleepiness Scale:	Never would doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0☐	1☐	2☐	3☐
2. Do you get sleepy, or doze off, while watching TV?	0☐	1☐	2☐	3☐
3. While sitting or inactive in a public place (meeting, theater)?	0☐	1☐	2☐	3☐
4. As a passenger in a car for an hour without a break?	0☐	1☐	2☐	3☐
5. Lying down to rest in the afternoon?	0☐	1☐	2☐	3☐
6. Sitting and talking to someone?	0☐	1☐	2☐	3☐
7. Sitting quietly after lunch without alcohol?	0☐	1☐	2☐	3☐
8. In a car, while stopped for a few minutes at a traffic light?	0☐	1☐	2☐	3☐
			(sum of all numbers checked above) Total Score	

CPAP:

Are you currently using CPAP? ☐ YES ☐ NO ☐ If yes, for how long? _____

Phone Number: 1-877-753-3776

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Date _____

Patient Name _____

Due to new insurance and Medicare *regulations* regarding preventive medicine services, it has become necessary to inform you that your complete physical examination **may or may not be fully covered by your insurance company.** This exam is a comprehensive overview of your current health status. We appreciate your patience and understanding in these new insurance regulations.

Please read all items carefully and initial to accept understanding. If you have any questions, please ask the receptionist. Thank you greatly for your cooperation.

- I fully understand that I am scheduled for a *Complete Physical Examination* _____
- I have received an information packet to have completed, either by mail or by pick up, that explained any and all the services entailed in this examination _____
- I fully understand that I am financially responsible for all the charges in the event that, 1) I step outside preventive parameters, 2) my insurance company denies all services, or 3) denies any part of these services _____
- I am fully aware that my insurance company *may not* cover *any* preventive medicine services and fully understand my financial obligation, *if* that were to be the outcome _____
- I fully understand that I may decline any service prior to receiving them _____

X _____
Patient Signature