VALLEY MEDICAL GROUP

Prevention & Medical Care To Help You Live Better, Longer.

ADULT RETURN PERSONAL HEALTH APPRAISAL (PHA)

This confidential information will be part of your medical record and will not be released without your authorization.

VISIT DATE

NAME		PATIENT ID #
AGE	DAY PHONE #	EVENING PHONE #

SINCE YOUR LAST CHECK-UP/PHA, HAS THERE BEEN ANY:

Change in marital or living status? ❍ Yes ☐ No

Occupation change? _____ Any hazardous exposures? ❍ Yes ☐ No

CONCERNS YOU WISH TO DISCUSS TODAY? _____

Compared to my last check-up, my health is: ☐ Improved ☐ The Same ❍ Worse

Does your health limit your activities in any way? ❍ Yes ☐ No How? _____

I have made the following changes in my health habits: _____

I have developed the following new medical problems: _____

I have had the following surgery or other procedures: (e.g., endoscopy, colposcopy, cryosurgery, dermatolgic surgery)

CURRENT MEDICATIONS: List all medications - include hormones, vitamins, over-the-counter medications, cremes, nasal sprays, antacids, inhalers, and eye drops. ☐ **Check here if NONE**

MEDICATION	STRENGTH	HOW OFTEN	MEDICATION	STRENGTH	HOW OFTEN

Birth control method? ☐ **N/A** _____

Any new allergies? _____

MEDICAL CONDITIONS

Have you developed any difficulties with:

- ❍ Bowel Movements or Bleeding
- ❍ Chest Discomfort
- ❍ Headaches
- ❍ Joints/Muscles/Back Pain
- ❍ Persistent Cough
- ❍ Skin Changes
- ❍ Urination
- ❍ Emotional Problems
- ❍ Stomach Pain/Heartburn
- ❍ Trouble Breathing
- ❍ Weight Loss or Gain
- ❍ Other (list)
- ☐ Check here if none of the above

Date of last eye exam: Date of last dental visit: _____

What other practitioners are you seeing? (e.g., specialists, chiropractor, acupuncturist, etc.?)

Have any members of your immediate family developed NEW:

❍ Cancer ❍ Heart Disease/Angina ❍ High Blood Pressure

❍ Diabetes ❍ Other

Have you ever had chicken pox, shingles or the vaccine?

☐ Yes ❍ No ❍ Unsure

Advice/Practitioner Comments

Go to page 2

MEN ONLY

- Have you had an undescended testicle? ..... ❍ Yes ☐ No
- Do you examine your testicles for lumps? ..... ☐ Yes ☐ No

WOMEN ONLY

- Do you have any breast lumps that have not been evaluated? .... ❍ Yes ☐ No
- Do you have discharge from your nipples? ..... ❍ Yes ☐ No
- Date of last menstrual period:_____
- Do you have problems with your period? ..... ❍ Yes ☐ No
- Do you have any questions about menopause? ..... ❍ Yes ☐ No

SCREENING TESTS

Cervical Cancer:

- After three normal, yearly pap smears, all women ages 21-65 (and sexually active teens) need to have a pap smear at least every 3 years. Date of your last pap smear? _____

Risk factors for women include:

- Sexual intercourse before age 16
- History of abnormal pap smear/cervical dysplasia
- Two or more sexual partners in the past 3 years
- History of hysterectomy for cancer
- History of sexually transmitted disease in the last 3 years
- Genital warts
- Genital herpes
- HIV+AIDS

- Could you be at risk for cervical cancer? ..... ❍ Yes ☐ No ❍ Unsure

Breast Cancer: Women at average risk should:

- Have periodic breast exams
- Do monthly self breast exams

- Have mammograms starting at age 50 at least every 2 years: ages 40-49 discuss mammogram schedule with practitioner ..... Date of last mammo:_____
- Do you examine your breasts monthly? ..... ☐ Yes ❍ No

Risk factors for breast cancer include:

- Personal History
- Mother or sister with breast cancer
- Abnormal breast biopsy
- No children

- Are you at risk for breast cancer? ..... ❍ Yes ☐ No ❍ Unsure

Cholesterol Testing: Recommended periodically depending on your age and risk.

- Has your cholesterol been checked in the past 5 years ..... ☐ Yes, Date: _____ ❍ No ❍ Unsure

Colon Cancer: All people over age 50 need colon cancer screening. Choices for screening are:

- Sigmoidoscopy at least every 10 years
- *or* annual stool test for blood
- *or* both of these

- Check any tests you have had and give most recent date:

___ Sigmoidoscopy	Date: _____	☐ Normal	❍ Abnormal
___ Stool card test for blood	Date: _____	☐ Normal	❍ Abnormal
___ Barium enema	Date: _____	☐ Normal	❍ Abnormal
___ Colonoscopy	Date: _____	☐ Normal	❍ Abnormal

Prostate Cancer: PSA screening and rectal exams for men have not been shown to be effective.

- Would you like more information about prostate cancer screening? ❍ Yes ☐ No

SEXUAL HEALTH

- How many sexual partners do you currently have? .....
  ☐ Men ☐ Women ☐ Both
- Risk factors for HIV infection are:
  - Multiple sexual partners (>1)
  - Blood transfusions between 1977 & 1985
  - Sex with prostitutes since 1977
  - Sex with a person with Hepatitis B
  - IV/"street drug" use
  - Hemophilia
  - Sex with a person at risk for HIV infection
- Could you be a risk for HIV infection? ..... ❍ Yes ☐ No ❍ Not sure
  If yes, do you use condoms? ..... ☐ Yes ❍ No ❍ Sometimes
- Do you have problems with sex or intercourse? ..... ❍ Yes ☐ No
- Are you currently using birth control? ☐ N/A .. ☐ Yes ❍ No ❍ Unsure
- Do you plan to have a baby in the future? ❍ Unsure ❍ Yes ☐ No

Advice/Practitioner Comments

Sexually transmitted diseases including AIDS/HIV can be prevented by:

- *abstaining from sex*
- *by practicing safer sex - using condoms*
- *limiting the number of sexual partners*
- *being monogamous (one sexual partner, long term)*

Ask us for information about how STDs/AIDS/HIV are transmitted/prevented and how to discuss condoms with a partner.

Go to page 3

LIFESTYLE REVIEW

Advice/Practitioner Comments

Tobacco

- Do you use tobacco products? ..... ❍ Yes ☐ No
- If yes, which products? ❍ cigarettes ❍ cigars/pipes ❍ snuff/chewing tobacco ❍ Other
- If yes: How many /day_____ How many years? _____
- If yes, Do you have plans to quit? ❍ in next month ❍ next 6 months ❍ next year ❍ not in next year

If you smoke, stopping is the best thing you can do for your health. Ask us about ways to quit.

Alcohol and Other Drugs

- How often do you have an alcoholic drink? (one drink is 12 oz. beer, 5 oz. wine, 1.5 oz. hard liquor) ☐ never ☐ once/month or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
- When you drink, how many drinks do you typically have? ☐ 1-2 ❍ 3-4 ❍ 5-6 ❍ 7-9 ❍ more than 10
- How often do you have six or more drinks? ☐ never ☐ once/month or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
- Have you ever thought you had an alcohol problem? ..... ❍ Yes ☐ No
- Have you ever driven when you had too much to drink? ..... ❍ Yes ☐ No
- Have you ever riden with someone who has had too much to drink . ❍ Yes ☐ No
- Do you sometimes use street drugs? ..... ❍ Yes ☐ No
- If yes, does your drug use sometimes cause problems? ..... ❍ Yes ☐ No

If you think you might have a problem with alcohol or drugs, ask us about local programs.

The Foods You Eat and Physical Activity

- Do you eat a low fat, high fiber diet? ..... ☐ Yes ❍ No
- Are you on any special diet? ..... ❍ Yes ☐ No (vegetarian, low fat, low salt, etc.) If yes, what?_____
- Have you made any changes in your eating habits to improve your health and well-being? ..... ❍ Yes ❍ No
- Are you presently exercising at least three times a week for 20-30 min? . ☐ Yes ❍ No

Regular exercise and lowfat, high fiber eating go a long way to help your health.

Accident Prevention Safety

- Do you always wear your seatbelt when driving or riding? ..... ☐ Yes ❍ No
- If you ride a bicycle, motorcycle, rollerblades, ski, snowboard, or horse do you always wear a helmet?..... ☐ N/A . ☐ Yes ❍ No
- Do you keep a gun at home? ..... ❍ Yes ☐ No
- Do you wear sunscreen, protective clothing and a hat when in the sun? . ☐ Yes ❍ No

Injuries, a major cause of death and disability, can often be prevented. Be safe.

Stress/Emotional Health

- In the past year did you have any major changes or problems? .... ❍ Yes ☐ No
  Major change/problem _____
  (e.g., personal/family relations, finances, job)
- Are you currently under treatment for clinical depression either in counseling or with medications? ..... ❍ Yes ☐ No
  If you answered Yes: Skip the next three questions.
  If you answered No: Answer the next three questions.
  - In the past year, have you had two weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? ..... ❍ Yes ☐ No
  - Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? ... ❍ Yes ☐ No
  - Have you felt depressed or sad much of the time in the past year? . ❍ Yes ☐ No
- Has anyone ever sexually, physically, or emotionally abused you? (e.g. repeated hitting, calling of names, or loud criticism; childhood sexual touching by someone older than you; or rape) ..... ❍ Yes ☐ No

Sometimes help is needed - stress management and counseling programs are available.

We encourage you to continue positive health habits and identify a new area to improve your health.

SELF-ASSESSMENT

- What health habits or risks would you like to work on changing:

❍ Stop Smoking ❍ Improve Nutrition ❍ Increase Exercise
❍ Stress Management ❍ Decrease alcohol/drug use ❍ None ❍ Other_____

- How confident are you that you will be able to make changes in your health habits checked above?

☐ Very confident ☐ Somewhat confident ❍ Not at all

END