



Adult New Member Physical
(Within 90 days of Enrollment)

Allergies: _____

Date: _____

Name: _____ ID#: _____ Sex: _____ Age: _____

Address: _____ Phone: _____

Primary Language: English Other List: _____ Advance Directives Acknowledgement: Yes No

◆ **Vital Signs:** BP _____ P _____ R _____ T _____ Ht _____ Wt _____
Visual Acuity 20/ _____

◆ **Past Medical/Surgical History** _____

◆ **Current Medications:** _____

◆ **Social History:** Alcohol _____ Tobacco _____ Drugs _____ Domestic Violence Screening Y N/A

◆ **Family History:** _____

◆ **Systems Review**

Constitutional	Fever <input type="checkbox"/> Y <input type="checkbox"/> N Weight Gain <input type="checkbox"/> Y <input type="checkbox"/> N Weight Loss <input type="checkbox"/> Y <input type="checkbox"/> N Night Sweats <input type="checkbox"/> Y <input type="checkbox"/> N Insomnia <input type="checkbox"/> Y <input type="checkbox"/> N	Renal/Urological Gynecologic	Dysuria <input type="checkbox"/> Y <input type="checkbox"/> N Urinary Hesitancy <input type="checkbox"/> Y <input type="checkbox"/> N Hematuria <input type="checkbox"/> Y <input type="checkbox"/> N Sexual Dysfunction <input type="checkbox"/> Y <input type="checkbox"/> N Genital Discharge <input type="checkbox"/> Y <input type="checkbox"/> N
Head and Neck	Visual Changes <input type="checkbox"/> Y <input type="checkbox"/> N Eye Pain <input type="checkbox"/> Y <input type="checkbox"/> N Nasal Bleeds <input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat <input type="checkbox"/> Y <input type="checkbox"/> N Hoarseness <input type="checkbox"/> Y <input type="checkbox"/> N Pain in Gums <input type="checkbox"/> Y <input type="checkbox"/> N Ear Pain <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Loss <input type="checkbox"/> Y <input type="checkbox"/> N	Musculoskeletal	Joint Pain <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Pain <input type="checkbox"/> Y <input type="checkbox"/> N Back Pain <input type="checkbox"/> Y <input type="checkbox"/> N Joint Swelling <input type="checkbox"/> Y <input type="checkbox"/> N
		Neurological	H/A <input type="checkbox"/> Y <input type="checkbox"/> N Seizure <input type="checkbox"/> Y <input type="checkbox"/> N Syncope <input type="checkbox"/> Y <input type="checkbox"/> N Weakness <input type="checkbox"/> Y <input type="checkbox"/> N Ataxia <input type="checkbox"/> Y <input type="checkbox"/> N Loss of Sensation <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Speaking <input type="checkbox"/> Y <input type="checkbox"/> N
Respiratory	Dyspnea <input type="checkbox"/> Y <input type="checkbox"/> N Hemoptysis <input type="checkbox"/> Y <input type="checkbox"/> N Cough <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N	Endocrine	Polyuria <input type="checkbox"/> Y <input type="checkbox"/> N Polydipsia <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue <input type="checkbox"/> Y <input type="checkbox"/> N
Cardiovascular	Chest pain <input type="checkbox"/> Y <input type="checkbox"/> N Palpitations <input type="checkbox"/> Y <input type="checkbox"/> N Pedal Edema <input type="checkbox"/> Y <input type="checkbox"/> N	Hematologic	Anemia <input type="checkbox"/> Y <input type="checkbox"/> N Easy Bruising <input type="checkbox"/> Y <input type="checkbox"/> N
Gastrointestinal	Dysphagia <input type="checkbox"/> Y <input type="checkbox"/> N Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N Constipation <input type="checkbox"/> Y <input type="checkbox"/> N Melena <input type="checkbox"/> Y <input type="checkbox"/> N Dyspepsia <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Pain <input type="checkbox"/> Y <input type="checkbox"/> N	Immunologic	Hives <input type="checkbox"/> Y <input type="checkbox"/> N Allergy to Foods <input type="checkbox"/> Y <input type="checkbox"/> N

Examination	√=Normal	Comments (required for abnormal findings)
General		
Head		
EENT		
Neck		
Chest and Lungs		
Breasts		
Cardiovascular		
Abdomen		
GU		
Rectal/Fecal Occult Blood Testing		
Female: Pelvic		
Extremities		

◆ **Diagnosis:** _____

◆ **Plans:** _____

◆ **Diagnostic Studies Ordered:** (required labwork) Urinalysis Hgb/Hct

◆ **Old Records** Requested From Dr: _____ Date: _____

◆ **Screening Requirements**

Cardiac			Diabetes			Female Member		
√=Ordered /Referred	---or---	Date Done/ Result	√=Ordered /Referred	---or---	Date Done/ Result	√=Ordered /Referred	---or---	Date Done/ Result
	LDL-C			HgbA1c			Mammogram	
	MI			LDL-C			PAP Test	
	Beta Blocker			Microalbuminuria			STD screen /Chlamydia	
	CHF			Eye Exam				
	ACE Inhibitor			Immunizations				
	LVEF-Echo or MUGA			Pneumococcal				
				Influenza				

Physician's Name: _____

Signature: _____

Original—Send to plan with claim form

Copy—Place on member's chart