PHYSICAL EXAMS AT STAMPS HEALTH SERVICES

1. You are **required** to be here at 8 am for your physical exam. All physicals are done at 8:15am. **If you are not here prior to your appointment time or do not show for your physical exam, you will be charged a $25 no show fee.**
2. Please do not eat or drink anything after midnight (other than water) the night prior to your physical appointment. **Please do not limit your water intake.**
3. If you routinely take medication in the morning, you may take it with water unless otherwise directed by your provider.
4. Travel visits and physical appointments require two separate appointments
5. **To schedule your appointment, please fax or *email these completed forms to either 404-894-1107, 404-385-0717, or physical@health.gatech.edu.**

**Before sending any forms via email, please be aware of the possible risks of using unencrypted e-mail. These forms contain protected health information and are confidential. The use of unencrypted e-mail and any attachment could result in an unintentional disclosure of your protected health information. If you use email, you have decided that the risks with e-mail communications are acceptable to you and you hereby release the Georgia Institute of Technology ("GIT") for any such disclosure unless caused by the negligence of GIT. If not, you may fax the forms to us.*

If you have any questions about scheduling a physical exam, please address them with the nursing staff prior to your physical exam.

Your appointment is scheduled for _____

with _____ in the _____ Care Team.

BLUE CARE TEAM: (404) 894-1423 GOLD CARE TEAM: (404) 894-0248

PLEASE CALL THE APPROPRIATE PHONE NUMBER TO CANCEL YOUR PHYSICAL APPOINTMENT 24 HOURS IN ADVANCE.

I UNDERSTAND THAT IF I AM NOT HERE PRIOR TO 8:15AM FOR MY PHYSICAL APPOINTMENT TIME OR 15 MINUTES PRIOR TO A TIME MY PROVIDER HAS APPROVED, I WILL BE CHARGED A NO SHOW FEE OF $ 25.00.

_____ _____

NAME DATE

_____

GT ID#

THANK YOU FOR ALLOWING US TO BE OF SERVICE TO YOU.

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GEORGIA INSTITUTE OF TECHNOLOGY

STAMPS HEALTH SERVICES

PREVENTATIVE CHECKLIST

Name: _____ GT ID#: _____

Date of Birth: _____ Age: _____ Phone: _____ Date of Exam: _____

MARITAL STATUS:

☐ Never Married ☐ Single, but live with a partner
☐ Married Currently ☐ Divorced/Separated ☐ Widowed

Medications: _____

Allergies: _____

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RACIAL BACKGROUND?

☐ White/Caucasian ☐ Black/African-American ☐ Asian-American or Pacific Islander
☐ Hispanic or Latino ☐ Native American ☐ Other: _____

MEDICAL CONDITIONS: Check all that apply to you now, or in the past

☐ Alcohol/Drug Problem ☐ Emphysema/Lung Problem ☐ Kidney Problems/Stones ☐ Allergy (hay fever)
☐ Fracture ☐ Liver Disease (cirrhosis, hepatitis) ☐ Anemia ☐ Glaucoma ☐ Panic Disorder ☐ Arthritis
☐ Gout ☐ Radiation Treatment ☐ Asthma ☐ Heart Murmur as an adult ☐ Seizures/Epilepsy ☐ Cancer
☐ Heart Trouble/angina ☐ Sickle Cell Disease ☐ Colon or Bowel Disease (includes polyps) ☐ Migraine
☐ High Blood Pressure ☐ Acne requiring oral medication ☐ Polycystic Ovarian Syndrome ☐ GERD/Acid Reflux
☐ Hemophilia or Bleeding Problems ☐ Stomach or Duodenal Ulcer ☐ Depression ☐ High Cholesterol
☐ Stroke ☐ Diabetes ☐ HIV or AIDS ☐ Thyroid Condition ☐ Emotional Problems
☐ Other Medical Problems (list): _____

PRIOR SURGERIES:

☐ Appendectomy ☐ Hysterectomy ☐ Splenectomy ☐ Fracture Repair ☐ Mastectomy ☐ Tonsillectomy
☐ Gallbladder Removed ☐ Ovaries Removed ☐ Tubal Ligation ☐ Hernia Repair ☐ Polyps Removed

Other surgical procedures (list): _____

YOUR FAMILY HISTORY:

Check if any blood relatives (parent, grandparent, aunt, uncle, brother, sister or children) have had any of the following: Fill in which relative has the problem.

☐ I do not know my family history

	Relative		Relative
☐ Alcohol/Drug Problem		☐ Mental illness/suicide/depression	
☐ Alzheimer's Disease		☐ Osteoporosis (brittle bones)	
☐ Breast Cancer		☐ Ovarian Cancer	
☐ Colon Cancer or Polyps		☐ Prostate Cancer	
☐ Depression		☐ Sickle Cell Disease	
☐ Diabetes		☐ Skin Cancer	
☐ Heart Attack Before 65		☐ Stroke Before Age 60	
☐ Hepatitis		☐ Thyroid Disease	
☐ High Blood Pressure		☐ Other Cancer	
☐ High Cholesterol		☐ Other	

Mother's Age _____ If deceased _____ Father's Age _____ If deceased _____

Number of: Sisters _____ Brothers _____ Children _____

SMOKING:

Do you smoke cigarettes, hookah, pipe, cigar, use snuff or chewing tobacco? ☐ Yes ☐ No
If yes: How many times/day? _____ How many years? _____
If yes: Do you have plans to quit?
☐ In the next month? ☐ Next 6 months ☐ Next year ☐ Not within the next year
If no: Have you ever smoked? ☐ No ☐ Yes Quit Date _____

ALCOHOL USE/DRUG USE:

How much alcohol (beer, wine, or hard liquor) do you typically drink? (Mark only one)

☐ None, ever
☐ I used to drink, but I quit
☐ Occasionally, or less than seven drinks per week
☐ Less than 14 drinks a week (2 a day)
☐ 14 drinks a week (2 a day) or more
☐ 28 drinks a week (4 a day) or more

In the last year, have you used recreational drugs (marijuana, cocaine, heroin, ecstasy, or any other illicit drug)?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often List: _____

SEXUAL HEALTH:

Have you ever been sexually active? ☐ Yes ☐ No Are you sexually active now? ☐ Yes ☐ No
What is your sexual preference? ☐ Male ☐ Female ☐ Both # of current partners _____ # lifetime partners _____
Have you ever been sexually or physically abused?
☐ No
☐ Yes, but it's not presently a problem for me.
☐ Yes, and it still causes significant problems for me

SEXUAL ACTIVITY/HIV RISK: (Your Answers will be kept confidential)

Check all that apply to you:

- ☐ Sexual intercourse before age 16
- ☐ History of abnormal pap smear
- ☐ Two or more sexual partners in last 3 years
- ☐ Prior sexually transmitted diseases
- ☐ Sex with prostitutes
- ☐ Sex with a person with Hepatitis B
- ☐ IV "street drug" use
- ☐ Blood transfusions between 1977 & 1985
- ☐ Sex with a person at risk for HIV infection

FAMILY PLANNING:

What, if anything, are you/partner doing to prevent pregnancy? (Mark one best answer)

- ☐ Does not apply to me (mark this one if you are not sexually active, if you or your partner have had surgery that prevents you from getting pregnant, or if you or your partner have stopped having periods.
- ☐ Birth control pill, Norplant, Depo Provera, IUD, a diaphragm, condom, cervical cap, or similar device
- ☐ We are trying to become pregnant
- ☐ Nothing, and I am sexually active

Other: _____

SCREENING TEST:

Check any screenings you have had and give the most recent date:

Dental Visit	Year: _____	☐ Normal	☐ Abnormal	☐ Don't Know
Eye Exam	Year: _____	☐ Normal	☐ Abnormal	☐ Don't Know
Sigmoidoscopy	Year: _____	☐ Normal	☐ Abnormal	☐ Don't Know
Rectal Exam	Year: _____	☐ Normal	☐ Abnormal	☐ Don't Know
Mammogram women)	Year: _____	☐ Normal	☐ Abnormal	☐ Don't Know
Pap Smear (women)	Year: _____	☐ Normal	☐ Abnormal	☐ Don't Know
Tuberculosis Screening	Year: _____	☐ Normal	☐ Abnormal	☐ Don't Know

IMMUNIZATIONS: if yes, list year

Tetanus Vaccine	Year: _____	☐ No	☐ Unsure
Measles, Mumps, Rubella	Year: _____	☐ No	☐ Unsure
Influenza Vaccine (flu shot)	Year: _____	☐ No	☐ Unsure
Pneumonia Vaccine	Year: _____	☐ No	☐ Unsure
Hepatitis B Vaccine	Year: _____	☐ No	☐ Unsure
Varicella Vaccine (Chicken Pox)	Year: _____	☐ No	☐ Unsure

WHAT OTHER PRACTITIONERS ARE YOU SEEING?

Such as specialists, chiropractors, acupuncturist, etc.

Check here if none ☐ If yes, list: _____

DIET/NUTRITION:

Are you on a special diet such as vegetarian, low fat, low salt, etc.? ☐ Yes ☐ No

If yes, what _____

How often do you eat food high in fiber, such as whole grain bread, cereal, pasta, rice, fresh fruit or vegetables?

☐ 5 or more servings a day ☐ 1-4 servings a day ☐ less than 1 serving a day

How often do you eat food high in fat or cholesterol, such as eggs, red meat, whole milk, cheese, doughnuts, ice cream, fried foods, chips, or similar foods?

☐ Once a week or less ☐ More than once a week, but not every day ☐ Once a day ☐ More than once a day

How many servings of caffeine do you have per day? Such as coffee, tea, cola, etc.

☐ None ☐ 1-2 ☐ 3-4 ☐ 5 or more

Do you use nutritional /herbal supplements?

If yes, list _____

ACTIVITY/EXERCISE:

In an average week, how many times do you exercise aerobically? Aerobic exercise can be anything that makes you breathe more heavily and your heart beat faster for at least 20 minutes.

☐ 3 or more times a week ☐ 1-2 times a week ☐ Occasionally, but not every week

☐ None ☐ None, but I do other forms of exercise

HABITS/SAFETY (Accident Prevention):

Do you have a working smoke detector in your home?	☐ Yes	☐ No
Do you always wear your seat belt?	☐ Yes	☐ No
Do you wear a bicycle/motorcycle helmet when riding?	☐ Yes	☐ No
Do you wear sunscreen and a hat when outdoors in the sun?	☐ Yes	☐ No