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 $35.00 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 $ 35.00.

____________________________________  ______________________________
NAME                                      DATE

____________________________________
GT ID#

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

Revised 11/24/15 KLC
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

<table>
<thead>
<tr>
<th>Relative</th>
<th>Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Problem</td>
<td>Mental illness/suicide/depression</td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td>Osteoporosis (brittle bones)</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Ovarian Cancer</td>
</tr>
<tr>
<td>Colon Cancer or Polyps</td>
<td>Prostate Cancer</td>
</tr>
<tr>
<td>Depression</td>
<td>Sickle Cell Disease</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Skin Cancer</td>
</tr>
<tr>
<td>Heart Attack Before 65</td>
<td>Stroke Before Age 60</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>Thyroid Disease</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Other Cancer</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Other</td>
</tr>
</tbody>
</table>

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 ☐ Less than 14 drinks a week (2 a day)
☐ I used to drink, but I quit ☐ 14 drinks a week (2 a day) or more
☐ Occasionally, or less than seven drinks per week ☐ 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)
- ☐ 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