Patient Information Sheet:

Patient Name _____ Date of Birth_____

Mailing Address: _____

City _____ State _____ Zip _____

Phone# (H) _____ SS# _____

Patient's Employer _____ Phone# _____

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Emergency Contact _____ Relation _____

Address _____ Phone# _____

Spouse's or Parent's Name _____ D.O.B _____

Employer _____ Phone# _____

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Primary Insurance Company _____ Name of Policy Holder _____

SS# of Policy Holder _____ D.O.B of Policy Holder __/____/____

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Local Visiting Address & Phone _____

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I hereby Authorize the office of Primary Medical Associates to release information that may be necessary for verifying insurance coverage, per certification, claim filing and referral treatment to another facility.

I understand the fees are due and payable at the time of service unless prior arrangements are made. This includes deductibles, co-pays and self pay. I hereby Authorize payment of medical benefits to the Physicians rendering services. I understand that I am financially responsible for charges not covered by my insurance.

I voluntarily consent to participate in treatment and understand that I will be kept informed of plans for my treatment and may withdraw this consent at any time with written notice. I also acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signed Date

Primary Medical Associates

James M. Vest, MD
Dan Muntean, MD
Mary Schustek, NP

1413 Highway 17 North
Surfside, SC 29575
843 238-5654

Patients Name: _____

Phone Number:_____

Can a message concerning your medical condition be left on an answering machine? YES___ NO___

Can a message concerning your medical condition be left on your cell phone voice mail? YES___ NO___

Cell Phone Number:_____

Who can a message concerning your medical condition be left with?

Name:_____ or No One_____

Can we call your work number? YES____ NO____

Work Number:_____

Patients Signature:_____

Date:_____

PMA Employee Witness:_____

Date:_____

Yearly Required Health Risk Assessment

Physical Activity
How many days of the week do you usually exercise
_____ days per week

On days when you exercise, for how long do you usually exercise?
_____ minutes per day
_____ does not apply

How intense is your typical exercise (check one)
_____ Light (stretching or slow walking)
_____ Moderate (brisk walking)
_____ Heavy (jogging or swimming)
_____ Very heavy (fast running or stair climbing)
_____ I am not currently exercising

Smoking / Tobacco Use
Do you currently smoke cigarettes or use other types of tobacco (check one)
_____ Yes
_____ No

Are you a former smoker?
_____ Yes
_____ No, I've never smoked

If you quit smoking, how long ago did you quite smoking cigarettes?
_____ Less than 6 months ago
_____ 1-5 years ago
_____ 6-10 years ago
_____ More than 10 years ago
_____ Does no apply

Do you use these other tobacco products? Check all that apply:
_____ Cigars
_____ Pipes
_____ Chewing tobacco / snuff
_____ I use no other tobacco products

Alcohol Use
In a typical week, how many days do you drink alcohol?
_____ days per week.
On days when you drink alcohol, how many alcoholic drinks do you consume?
_____ drinks per day.
In a typical week, how often do you have 5 or more alcoholic drinks on one occasion?
_____ never
_____ once a week
_____ 2-3 times per week
_____ more than three times per week

Nutrition
On a typical day, how many servings of fruits and/or vegetables do you eat (1 serving equals 1 cup of fresh vegetables, a 1/2 cup of cooked vegetables or one medium piece of fruit. One cup is about the size of a baseball.
_____ servings per day

On a typical day how many servings of high fiber or whole grain foods do you eat? One serving equals one slice of 100% whole grain bread, One cup of grain or high fiber cereal, 1/2 cup of cooked cereal (oatmeal) or 1/2 cup of cooked brown rice or whole wheat pasta.
_____ servings per day

On a typical day, how many servings of fried or high fat foods do you eat? Examples: fried chicken, fried fish, bacon/pork, french fries, potato chips, corn chips, doughnuts, creamy salad dressings, foods made with whole milk, cream, cheese or mayonnaise.
_____ servings per day

Motor Vehicle Safety
Do you always fasten your seal belt when you are in the car?
_____ yes
_____ no

Do you ever drive after drinking or ride with a driver who has been drinking?
_____ yes
_____ no

Sun Exposure
Do you protect yourself from the sun when you are outdoors?
_____ yes
_____ no

Blood Pressure
If your blood pressure was checked within the past year, what was the result?
_____ low or normal (at or below 120/80)
_____ borderline high (120/80 to 139/89)
_____ high (140/90 or higher)
_____ do not know
_____ does not apply

Cholesterol
If your cholesterol was checked within the past year, what were your total cholesterol results?
_____ desirable (below 200)
_____ borderline high (200-239)
_____ high (240 or higher)
_____ do not know
_____ does not apply

Blood Glucose
If your glucose (sugar) was checked within the past year, what was the results of your fasting glucose level?
_____ desirable (below 100)
_____ borderline high (100-125)
_____ high (126 or higher)
_____ do not know
_____ does not apply

Have you ever been told by a doctor or health professional that you have diabetes or high blood sugar?
_____ yes
_____ no

If you have had your hemoglobin A-1-C checked within the past year, what was the result?
_____ desirable (6 or lower)
_____ borderline high (7)
_____ high (8 or higher)
_____ do not know
_____ does not apply

Height / Weight
What is your height?
_____ feet _____ inches

What is your weight?
_____ pounds

Depression
Over the past two weeks, have you felt down, depressed or hopeless?
_____ almost all the time
_____ most of the time
_____ some of the time
_____ almost never

Over the past two weeks, have you felt a lack of interest or pleasure in doing things?
_____ almost all the time
_____ most of the time
_____ some of the time
_____ almost never

Have your feelings caused you distress or have they interfered with your ability to interact socially with friends?
_____ yes
_____ no

During the past six months how often have you felt depressed or sad?
_____ almost all the time
_____ most of the time
_____ some of the time
_____ almost never

In general, bow satisfied are you with your life?
_____ very satisfied
_____ satisfied
_____ dissatisfied
_____ ver dissatisfied

High Stress
How often is stress a problem for you?
_____ never / rarely
_____ sometimes
_____ often
_____ always

How well do you handle the stress in your life?
_____ I am usually able to cope effectively
_____ at times I have problems coping
_____ I often have problems coping

General Well-Being
In general, would you say your health is:
_____ excellent
_____ very good
_____ fair
_____ poor

Social Emotional Support
How often do you get the social and emotional support you need?
_____ always
_____ usually
_____ sometimes
_____ rarely
_____ never

General Life Satisfaction
In general, how satisfied are you with your life?
_____ very satisfied
_____ satisfied
_____ dissatisfied
_____ very dissatisfied

Sleep
_____ how many hours of sleep do you usually get each night?

Daily Aspirin Use
Have you discussed taking a daily aspirin with your doctor?
_____ yes
_____ no

Medical History
Have you ever had any major illness or accident that caused you to be hospitalized?
_____ yes
_____ no

If yes, describe the incident:
_____

_____

_____

List any surgeries you have had (include any removals: tonsils, spleen)
_____

_____

_____
List any doctors, nurse practitioners or physician assistant that you currently see.
_____

_____

_____

Have you had a bone mineral density screening?

_____ yes _____ year
_____ no

Have you had a colonoscopy?
_____ yes _____ year
_____ no

FAMILY HISTORY

MEDICAL PROBLEMS	Father	Mother	Father's Parents	Mother's Parents	Brothers / Sisters	Children
Heart Disease						
High Blood Pressure						
Stroke TIA						
Cancer						
Seizures						
Diabetes						
Liver Disease						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Sickle Cell						
Bleeding Disorders						

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MEDICAL HISTORY (Please Check if you have a history of the following)

__ Eye problems
__ Rheumatic fever
__ Bowel irregularity
__ Gall bladder disease
__ Prostate disease
__ Bladder/urinary
__ Dizziness/fainting
__ Venereal disease
__ Vascular disease
__ Hepatitis/Liver
__ Ulcer
__ Headache
__ Heart disease
__ High cholesterol
__ Chest Pain
__ Menstrual Irregularity
__ Allergies/Hay fever
__ Seizures
__ AIDS
__ Anemia
__ Lung Disease
__ Asthma
__ Arthritis
__ Bronchitis
__ Anxiety
__ Depression

_____

List any medication reactions or allergies:

_____

_____

_____

Have you ever been tested for glaucoma?
_____ yes _____ year _____ eye doctors name
_____ no

Females Only:
When was you last mammogram?
_____ (mm/dd/yy)
_____ number of pregnancies
_____ number of deliveries
_____ last menstrual period

Males Only:
When was your last prostate exam?
_____ (mm/dd/yy)

Have you ever had the pneumonia vaccine?
_____ yes _____ year or age
_____ no

If you are over 50 have you had the shingles vaccine
_____ yes _____ year or age
_____ no

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Advanced Care Planning

Do you have a Living Will?
_____ yes
_____ no
_____ do not know what it is

Have you appointed anyone as your healthcare power of attorney?
_____ yes
_____ no
_____ do not know

Would you like information on completing Advanced Directives such as a Living Will or health care power of attorney?
____ yes
____ no