Physical Exam

First Name	Last Name	Date of Birth

Thank you for choosing Brio Primary Care! You are scheduled for your yearly preventative exam. The purpose of this exam is to identify potential health problems in the early stages when they may be easier and less costly to treat.

A routine preventative exam is defined as a periodic comprehensive preventative medical evaluation and management and includes the following:

- Past medical, social, and family history
- Complete physical exam and review of body systems
- Review of medications and immunization history
- Routine medication refills
- Counseling / anticipatory guidance / risk factor reduction interventions
- Review of age / gender appropriate screening tests

The routine preventative exam is not meant to evaluate, diagnose, or treat existing health problems. This exam is prevention-focused rather than problem-focused. That means it is designed to prevent minor issues from becoming serious. If you have a new or existing problem that needs to be addressed during your preventative office visit, such as high blood pressure, Diabetes, skin rash, high cholesterol, headaches, etc., your Provider may bill part of the exam as your annual preventative exam, and part of the exam as treatment of your diagnosis. You may be offered an additional appointment to discuss those issues. Any new or existing problems that are reviewed or addressed as a part of your preventative exam may create additional charges.

We will file your insurance for you and you will be responsible for any portion of this exam that your insurance does not cover, whether it is for uncovered preventative services or disease management.

Patient Signature Name	Date Completed

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PRIMARY CARE
with MUSC Health

Physical Exam

_____ _____ _____
First Name Last Name Date of Birth

Preventative Healthcare Screening

Please indicate the date of your last screenings. Leave blank if not applicable.

Hepatitis C Screening Date: _____ Completed At: _____

HIV Screening Date: _____ Completed At: _____

Colorectal Screening (Ages 45-75)

Colonoscopy Date: _____ Completed At: _____
Results: Normal ☐ Abnormal ☐

Cologuard Date: _____ Completed At: _____
Results: Normal ☐ Abnormal ☐

Eye Exam (Diabetic Patients Only)

Completed At: Jervey Eye ☐ Southern Eye ☐ Other ☐

Cervical Screening (Female Patients Only)

Pap Smear Date: _____ Completed At: _____
Results: Normal ☐ Abnormal ☐

Hysterectomy Date: _____ Completed At: _____

Breast Screening (Female Patients Only)

Mammography Date: _____
(Age 40-74)
Completed At: St Francis ☐ PRISMA ☐ Innervision ☐ Other ☐
Results: Normal ☐ Abnormal ☐

Osteoporosis Screening (Bone Density Measurement)

DEXA Date: _____

Physical Exam

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_____	_____	_____

Social History

What is your marital status? _____

Are you in a relationship with a male partner? Yes ☐ No ☐

Are you in a relationship with a female partner? Yes ☐ No ☐

Are you sexually active? Yes ☐ No ☐

What is your occupation? _____

How often do you spend time with others?

None ☐ I prefer isolation ☐ Occassional Interaction ☐ Frequent Interaction ☐

Immunizations

Please indicate the date of your last immunizations. Leave blank if not applicable.

PCV21 (Pneumonia Vaccine) Date: _____

Hepatitis B Date: _____

HPV (Gardasil Vaccine) Date: _____

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_____	_____	_____

SBIRT (2018 Edition)

Alcohol Use

How often do you have a drink containing alcohol?

☐	☐	☐	☐	☐
Never	Monthly Or Less	2 - 4 Times A Month	2 - 3 Times A Week	4 or More Times A Week

How many drinks containing alcohol do you have on a typical day when you are drinking?

☐	☐	☐	☐	☐
1 or 2	3 or 4	5 or 6	7 or 9	10 or More

How often do you have five or more drinks on one occasion?

☐	☐	☐	☐	☐
Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily

Drug Use

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

☐	☐	Total Count: _____
0	1 or More	

This screening form is a health evaluation measure we are required to have you complete once a year at your annual exam. Your insurance will be billed for this form as a part of your visit today.

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First Name _____ Last Name _____ Date of Birth _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half of the Days	Nearly Every Day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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Social History Question

Does a partner, or anyone at home, hurt, hit, or threaten you? Yes ☐ No ☐