

Good morning "Respectful,
Evidence-based,
Collaborative Care"



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University South

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Patient Information / Personal Health Record

Name: _____ . Date of Birth: _____ . Date: _____ .

Please don't rush. Provide as much information as possible. This Two-Page form helps us provide you with optimal care. Thank you for your patience and attention to detail in completing both sides.

What first name do you go by? _____ . Occupation (past or present): _____ .

Retired? Yes No. Marital Status: Single. Married. Divorced. Separated. Widowed (year? _____).

Number of Children _____ . Education (maximum achieved): _____ .

Hobbies: _____ . Religious Preference: _____ . None .

Race: _____ . What is your height? _____ . What is your desired weight? _____ .

Past Medical and Family History: Check the box and, where listed, circle "Y" for conditions You have, then "F" for Father, "M" for Mother, "B" for Brother and "S" for Sister. Please don't rush, your Medical and Family History is very important.

Father living? Yes No. Age _____ ? Mother living? Yes No. Age _____ ? Please list approximate age, if deceased.

Total number of brothers (even if deceased) _____ ?

Total number of sisters _____ ?

- Acid Regurgitation? Restless legs syndrome? Kidney Disease? Y F M B S Lung cancer? Y F M B S
Ulcer? Blood Clots? (legs, lungs) Osteoarthritis? Y F M B S Colon cancer? Y F M B S
Pre-diabetes? High Blood Pressure Y F M B S Rheumatoid arthritis Y F M B S Prostate cancer? Y F M B S
Enlarged prostate? Heart Disease? Y F M B S Thyroid Disease? Y F M B S Breast Cancer? Y F M B S
Excessive anxiety? Heart Valve abnl? Y F M B S Asthma? Y F M B S Melanoma? F M B S
History of Transfusion? Stroke? Y F M B S Emphysema? Y F M B S Other Cancer (list below): Y F M B S
Legally Blind or Deaf? Osteoporosis? Y F M B S Sleep Apnea? Y F M B S Depression? Y F M B S
Fibromyalgia? Diabetes? Y F M B S Migraine? Y F M B S Suicide? F M B S
Recurring vertigo? High Cholesterol Y F M B S Seizures? Y F M B S Drug and/or Alcohol misuse? (please circle) Y F M B S
Irritable bowel syndrome? Liver Disease? Y F M B S Alzheimer's? Y F M B S

Other Conditions? _____

Past Surgical History: Please check all that apply and add the approximate year of the procedure. Add other surgery not listed.

- Cataract Surgery _____ Hernia Surgery _____ Hysterectomy _____ Heart Bypass Surgery _____
Tonsillectomy _____ Joint Surgery _____ Ovaries removed _____ Carotid artery Surgery _____
Appendectomy _____ Skin Cancer Surgery _____ Cosmetic Surgery _____ Vein surgery _____
Gallbladder _____ Prostate Surgery _____ Other: _____

List all other Professionals you see (Specialists, Chiropractor, Acupuncture, Counselor etc.) _____

Drug Allergies (rash, swelling, etc.)? _____ . None .

Drug Intolerance (nausea, groggy, etc.)? _____ . None .

Prescription Medications: include dosage and frequency taken (twice a day, etc.). If needed, list on a separate sheet (please ask).

Over-the-counter medications (please list everything, including the dosage): _____

Do you have a Living Will? Yes No. If no, would you like one? Yes No.

Year of last Eye exam _____? Year of last Dental exam _____?

Do you use a hand held cell phone while driving (significantly higher accident rate)? Yes No.

Do you Exercise regularly (3+ per week)? Yes No. Are you at a healthy weight? Yes No.

Is your nutrition balanced? Yes No.

Do you use any nicotine products? Never. Former. Now. For cigarette smokers, now or in the past, about how many packs a day _____, for about how many years _____? For former smokers, what year did you quit? _____.

Alcohol use: None. Less than 7 drinks a week. 7-14 drinks a week. More than 14 a week.

The following immunizations are recommended by National vaccine experts.

Tetanus/Diphtheria/Pertussis within 10 years? Yes. No. If yes, when?_____. Do you want one? Yes. No.

Pneumonia vaccine (for smokers, asthma, COPD and 65+ yrs old) Yes. No. Year?_____. Do you want one? Yes. No.

Everyone over 60 years old: Zostavax ("Shingles vaccine")? Yes. No. Year?_____. Do you want one? Yes. No.

Gardasil: (to prevent cervical cancer in women, ages 9-26 y.o.)? Yes. No. Year?_____. Do you want one? Yes. No.

Hepatitis B series (3 shots)? Yes. No. Year?_____. Hepatitis A series (2 shots)? Yes. No. Year?_____.

Prevention Most health plans recommend and pay for a, prevention oriented, Health Maintenance Examination every one to five years to preserve health and screen for preventable disease. Would you like us to schedule a Health Maintenance Examination? Yes. No. (This exam is for prevention only. A different appointment is advised to address problems requiring further evaluation and management.)

Everyone over age 50: Have you had screening for colon cancer? Yes. No. If "yes", what year _____ and with what test
Stool test for hidden blood. Colonoscopy (best). Flexible sigmoidoscopy. Barium enema X-ray.

Women's Health: The U.S. Preventive Services Task Force (USPSTF) strongly recommends Pap test screening for cervical cancer in sexually active women with an intact cervix.

Year of your last PAP test?_____, NI. Abnormal

"Well Woman" care is available at this office with Mary Toner, ARNP or Dr. Ken Mayer M.D.

Year of your last Mammogram?_____, NI. Abnormal

Year of your last Bone Density test (if over age 60)?_____, NI. Abnormal

Men's Health: Prostate Cancer Screening: Screening for prostate cancer involves testing men who are not having symptoms of prostate cancer (see symptoms listed below). Screening is usually done through a Prostate Specific Antigen (PSA) blood test with or without a digital rectal examination (DRE). Unfortunately, current screening tests are not highly accurate. An abnormal PSA or digital rectal exam is not uncommon and is not due to cancer 70% of the time. However, referral to a Urologist for multiple prostate biopsies is the standard approach to evaluate the abnormal screening test

Symptoms of prostate cancer can include; Blood in the urine, The need to urinate frequently, especially at night, Weak or interrupted urine flow, Pain or burning feeling while urinating, The inability to urinate or Constant pain in the lower back, pelvis, or upper thighs.

Have you noticed any of the urinary symptoms mentioned above? Yes. No

As of August 2008, the US Preventive Services Task Force concludes that "current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years". They go on to "recommend against screening for prostate cancer in men age 75 years or older".

- I request prostate cancer screening with the PSA blood test. Yes. No.
- I request prostate cancer screening with a digital rectal exam. Yes. No.
- I need to discuss this further before deciding. Yes. No.