



JUPITER FAMILY HEALTHCARE

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www.jupiterfamilyhealthcare.com

Dear Patient:

To insure that your physical examination is of the highest quality and comfort, please observe the following:

PHYSICAL EXAM NOTES

Please bring the Physical Exam forms completely filled out with you on the day of your scheduled exam.

Use an ink pen to fill out the Physical Exam forms writing your name and the date on top of each page.

On the day of your examination:

PLEASE DO NOT USE BODY LOTIONS.

PLEASE DO NOT USE PERFUME OR COLOGNE AFTER YOUR BATH.

WEAR LOOSE FITTING CLOTHING.

PLEASE DO NOT WEAR PANTYHOSE.

It is advisable to leave small children at home so that the physician has your complete attention during the examination.

Please call the member services number on the back of your insurance card and ask if the physical examination will be covered and what tests may or may not be covered during the physical examination, i.e. blood work, EKG, chest x-ray, etc.

If you have not eaten or drank any liquid (except for sips of water) for at least 8 hrs on the day of your examination, your laboratory studies can be done on the same day. If you are unable to wait that long for a meal, then your laboratory studies will be scheduled for another day.

If you decided to go without food or drink until your visit, you may take your medications at the normal time with small sips of water.

There will be a \$50 charge for any physical not cancelled within 24 hours prior to your appointment.

Thank you,

THE STAFF AT JUPITER FAMILY HEALTHCARE



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PHYSICAL EXAM

I, _____, understand that my physical exam is
(print name)

considered routine. Some insurance policies do not cover routine exams. If my insurance policy does not cover the Physical Exam, I will be responsible for the payment in full.

Signature

MEDICARE PHYSICAL EXAM

I, _____, understand that my physical exam is
(print name)

not a covered benefit of Medicare. If my secondary insurance policy does not cover the Physical Exam, I will be responsible for the payment in full.

Signature

JUPITER FAMILY HEALTHCARE

NAME _____

Date ___/___/___

REVIEW OF SYSTEMS:

1. GENERAL:

	Yes	No
Do you usually feel persistently tired or worn out?	___	___
Have you recently been drinking more water or fluids?	___	___
Has there been any unusual weight gain or loss recently?	___	___

2. CARDIOVASCULAR:

Do you have pain, tightness or pressure in the front or back of your chest?	___	___
Does your heart ever beat fast or irregularly?	___	___
Do you have any swelling of your feet or ankles?	___	___
Do you have cramps in the calf muscles when you walk?	___	___
Do your fingers or toes ever get cold, become numb, or get very white or bluish?	___	___
Have you ever been told you have a heart murmur?	___	___

3. CENTRAL NERVOUS SYSTEM:

Do you have frequent or severe headaches?	___	___
Do you often have spells of dizziness, faintness or lightheadedness?	___	___
Have you recently fainted, blacked out, lost consciousness?	___	___

4. EYES: Have you had:

Any pain in your eyes?	___	___
blurry vision?	___	___
change in vision?	___	___
cataracts or implants?	___	___
When did you last see an eye doctor?	_____	

5. ENT: Do you have:

any trouble hearing?	___	___
ringing or buzzing in your ears?	___	___
persistent hoarseness?	___	___
Sinus trouble?	___	___
Do you use a hearing aid?	___	___
When did you last visit a dentist?	_____	

6. GASTROINTESTINAL:

Have you recently noted any trouble swallowing?	___	___
Do you have a lot of indigestion or heartburn?	___	___
Have you ever vomited blood?	___	___
Are you bothered by constipation?	___	___
Do you have frequent loose stools or diarrhea?	___	___
Have you recently had any change in the frequency of bowel movements?	___	___
Do you have blood in your stool or black tarry stool?	___	___

7. SKIN: Do you have:

any rashes or itching?	___	___
any growths or lumps on your skin?	___	___
any sores or wounds that do not heal?	___	___
any change in the color or size of warts or moles?	___	___
any change in your nails?	___	___

JUPITER FAMILY HEALTHCARE

NAME _____

Date ___/___/___

	Yes	No
8. GENITOURINARY: Do you have:		
burning or pain when you urinate?	___	___
to pass water frequently?	___	___
to get up at night to urinate?	___	___
How often? _____ times per night	_____	_____
trouble starting or stopping your urine?	___	___
trouble with losing urine when you cough or sneeze?	___	___
Have you ever passed blood in your urine?	___	___
Have you ever had an operation to prevent pregnancy? (Vasectomy or sterilization, such as a tubal ligation)	___	___
 9. MUSCULOSKELETAL: Do you have:		
a problem with back pain?	___	___
joint pain or stiffness (arthritis)?	___	___
trouble walking or using your hip, knee joints?	___	___
numbness or tingling in your arms or legs?	___	___
 10. RESPIRATORY: Do you have:		
a constant or bothersome cough?	___	___
coughing up blood?	___	___
difficulty breathing at rest or exercise?	___	___
a history of a positive reaction to a tuberculosis (TB) skin test?	___	___
 11. PSYCHIATRIC: Do you have:		
feelings of depression?	___	___
feelings of anxiety/nervousness/tenseness?	___	___
problems with your temper?	___	___
problems with memory?	___	___
have trouble sleeping?	___	___
 12. ENDOCRINE: Do you have:		
thyroid trouble?	___	___
heat or cold intolerance?	___	___
excessive sweating, thirst or hunger?	___	___
 13. HEMATOLOGIC/ANEMIA:		
Do you bruise or bleed easily?	___	___
Are you anemic?	___	___
Do you notice any lumps in your neck, armpits or groin?	___	___
 14. MEN ONLY:		
Do you have prostate gland trouble?	___	___
Have you had herpes?	___	___
Do you have any discharge or drip from your penis?	___	___
Do you know how to examine your testicles?	___	___
If so, do you do this at least monthly?	___	___

JUPITER FAMILY HEALTHCARE

NAME _____

Date ___/___/___

14. WOMEN ONLY:

Yes No

Date of last period _____			
Was your last period normal?		___	___
Have you passed the menopause or change?		___	___
If so, what year? _____			
Date of last Pap smear _____			
Was your last Pap smear normal?		___	___
Date of last mammogram _____			
Was your last mammogram normal?		___	___
Did you have any pregnancies?		___	___
How many? _____			
Premature _____ Full Term _____ Abortions _____ Miscarriages _____			
Do you know how to examine your breasts?		___	___
How often do you examine your breasts? _____			
Do you have any:			
any lumps in your breasts?		___	___
discharge from your nipples?		___	___
vaginal drainage?		___	___
prolapse ("falling out") of the vagina or uterus?		___	___
any abnormal bleeding from the vagina in the past year?		___	___
Have you had herpes?		___	___