



JUPITER FAMILY HEALTHCARE

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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 considered
(print name)
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.

If anything other than routine / preventative health is discussed at the time of the routine physical, it may result in extra charges or denial of your insurance claim and you may be billed for this service. If you are unsure of coverages, you may schedule a separate appointment to discuss any other health concerns or medical problems.

Signature

MEDICARE PHYSICAL EXAM

I, _____, understand that my physical exam may not be a
(print name)
covered benefit of Medicare. Some secondary insurance policies do not cover routine exams. If Medicare or my insurance policy does not cover the Physical Exam, I will be responsible for the payment in full.

If anything other than routine / preventative health is discussed at the time of the routine physical, it may result in extra charges or denial of your insurance claim and you may be billed for this service. If you are unsure of coverages, you may schedule a separate appointment to discuss any other health concerns or medical problems.

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?	___	___

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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?	_____	_____