PATIENT HEALTH HISTORY FORM DIRECTIONS AND VISIT DAY INSTRUCTIONS

Prior to your Appointment:

STEP 1: Forms

Please complete all the attached forms and bring them with you on the day of your visit.

STEP 2: Labs

Please have your labs drawn "at least" one week prior to your appointment if you would like to discuss your results at that time of you visit

PLEASE FAST for 12 hours before your labs.

~ **Enclosed** you will find your lab order which can be done prior to your visit.

Note: Labs for Wellness Exam can ONLY be drawn at the
QUEST DIAGNOSTICS 805 Locust Street, Philadelphia, PA, 19107
Hours are: Mon-Fri: 7:00am – 3:30pm
Office is closed for Lunch from 12:00 pm – 1:00 pm
MDVIP Membership Fee includes the cost of the labs.
*****If you take this lab slip to any other lab you WILL be charged an out of pocket fee.***

STEP 3: (optional) MDVIP Patient Portal

~ Available on the MDVIP portal is the *Interactive Health Assessment* that is a tool that will help you identify your health risks.

If you do not have a username & password and would like one, please contact:
MDVIP Corporate at 1-866-696-3847 or online @ connect.mdvip.com/request-registration-key

On the Day of your Appointment:

- Please do not wear any perfumes, lotions or oils, since they may interfere with an ECG tracing.

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Established Patient Forms

Please complete these forms in advance of your appointment and bring them with you. Thank You.

Name:_____ **DOB:**_____

Date:_____

Please complete these forms in advance of your appointment and bring them with you. Thank You.

What **problems** do you wish to discuss with the doctor during your evaluation today?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have an Advance Directive? Yes / No

Please list any **NEW** allergies to medications**:** Drug / Reaction

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Surgical History:

Please list any surgeries from the last year	**Date**

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In the last few weeks have you had problems with any of the following?

Falls:	**( )Yes ( ) No**
Fatigue:	**( )Yes ( ) No**
Chest Pain:	**( )Yes ( ) No**
Sortness of Breath:	**( )Yes ( ) No**
Palpitations:	**( )Yes ( ) No**
Leg Swelling:	**( )Yes ( ) No**
Rash :	**( )Yes ( ) No**
Nasal Congestion:	**( )Yes ( ) No**
Sore Throat:	**( )Yes ( ) No**
Hearing Loss:	**( )Yes ( ) No**
Post Nasal Drip:	**( )Yes ( ) No**
Dizziness:	**( )Yes ( ) No**
Abdominal Pain:	**( )Yes ( ) No**
Nausea:	**( )Yes ( ) No**
Vomiting:	**( )Yes ( ) No**
Heart Burn:	**( )Yes ( ) No**
Indigestion:	**( )Yes ( ) No**
Diarrhea:	**( )Yes ( ) No**
Constipation:	**( )Yes ( ) No**
Change in Bowel Habits:	**( )Yes ( ) No**
Blood in Stool:	**( )Yes ( ) No**
Hemorrhoids:	**( )Yes ( ) No**
Bleeding Problems:	**( )Yes ( ) No**
Clotting Problems:	**( )Yes ( ) No**
Joint Pain:	**( )Yes ( ) No**
Back Pain:	**( )Yes ( ) No**
Headache:	**( )Yes ( ) No**
Tingling/Numbness:	**( )Yes ( ) No**
Sleep Problems:	**( )Yes ( ) No**
Visual Changes:	**( )Yes ( ) No**
Memory Loss:	**( )Yes ( ) No**
Anxiety:	**( )Yes ( ) No**
Sleep Disturbances:	**( )Yes ( ) No**
Urinary Frequency:	**( )Yes ( ) No**
Urinary Urgency:	**( )Yes ( ) No**
Blood in Urine:	**( )Yes ( ) No**
Urinary Incontinence:	**( )Yes ( ) No**
Kidney Stones:	**( )Yes ( ) No**

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MDVIP LONG LIVE HEALTHY

Social History

Please answer the following questions.

What is your Marital Status? () Single () Married () Partnered () Divorced/ Separated () Widowed

How many people in household? () 1 () 2 () 3 () 4 ()5+

Highest education level? () High School () College () Graduate

Do you use recreational drugs? () Yes () No

Are there guns in your home? () Yes () No

Do you have a working smoke detector at home? () Yes () No

Do you exercise? () Never () Occasional () 1-2 Days a week () 3+ Days a week

Any questions about sex that you would like to discuss with the doctor? () Yes () No

Do you have regular eye care? () Yes () No

Do you have regular dental cleanings? () Yes () No

Are you on a special diet? () Yes () No

Have you've been a victim of abuse? () Yes () No

How is life in general? () Disastrous () Fair () Good () Very Good () Excellent

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MDVIP LONG LIVE HEALTHY

Burns Checklist ~ PHQ-9

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

(Use "x" to indicate your answer)

	~ 0 ~ Not at all	~ 1 ~ Several days	~ 2 ~ More than half the days	~ 3 ~ 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 feeling that you are a failure or that you have let yourself or your family down				
7) Trouble concentrating on things such as reading or watching TV				
8) Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual				
9) Thoughts that you would be better dead or that you want to hurt yourself in some way				

Beck Index

How much you have been bothered by each symptom in the past week, including today....	~ 0 ~ None Not at all	~ 1 ~ Mildly Didn't bother me much	~ 2 ~ Moderately Unpleasent, but could stand it	~ 3 ~ Severely Could barely stand it
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of the worst happening				
Dizzy or lightheaded				
Heart pounding or racing				
Unsteady				
Terrified				
Nervous				
Feelings of choking				
Hands trembling				
Shaky				
Fear of losing control				
Difficulty breathing				
Fear of dying				
Scared				
Indigestion or discomfort in abdomen				
Faint				
Face flushed				
Sweating (not due to heat)				

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MDVIP LONG LIVE HEALTHY

The CAGE and CAGE-AID Questionnaire

Do you drink alcohol?	◯ Yes	◯ No
Have you ever experimented with drugs?	◯ Yes	◯ No
In the last three months, have you felt you should cut down or stop drinking or using drugs?	◯ Yes	◯ No
In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?	◯ Yes	◯ No
In the last three months, have you felt guilty or bad about how much you drink or use drugs?	◯ Yes	◯ No
In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?	◯ Yes	◯ No

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