1017 Dupont Road, Ste B Louisville, KY 40207
Office/Appointments: (502) 947-2273 Fax: (502) 947-2274

Annual Physical Medical Record#: ___________

Today's Date:	**Primary Care Provider:**
Name:	**Date of Birth:**

Have there been any changes to the following? If so, please list the changes.

Address: □ Yes □ No ____________________

Phone Number:: □ Yes □ No ____________________

Insurance: □ Yes □ No ____________________

Pharmacy: □ Yes □ No ____________________

Any **New** Allergies: □ Yes □ No ____________________

Medication Allergies: **Food Allergies:** **Other Allergies:**

List any medications or **CHANGES** to medications below.

Name of Medication:	Dosage:	How often do you take?	Provider that Prescribed:	The date that you started taking?

Have there been any medical diagnoses since your last visit? If So, Check All That Apply	
□ Anemia □ Angina (Chest Pain) □ Anxiety □ Arthritis (Osteoarthritis/Rheumatoid) □ Asthma □ Benign Prostatic Hypertrophy (BPH) □ Bleeding Disorder □ COPD □ Cancer (type) ___________________ □ Cataracts □ Chronic Back Pain □ Chronic UTI □ Congestive Heart Failure □ Coronary Artery Disease □ Depression □ Diabetes □ Diverticulosis □ Erectile Dysfunction □ Fibromyalgia □ GERD (Acid Reflux/Indigestion	□ GOUT □ Glaucoma □ Headache/Migraine □ Heart Attack □ Hepatitis/ Liver Disease □ High Blood Pressure □ High Cholesterol □ HIV/AIDS □ Inflammatory Bowel Disease □ Insomnia □ Irregular Heartbeat _________________ □ Osteoporosis □ Peptic Ulcer Disease □ Peripheral Vascular Disease □ Polyneuropathy □ Renal/Kidney Disease □ Seasonal Allergies □ Seizure Disorder □ Sleep Apnea □ Stroke/TIA
Have you had any surgeries since your last visit? If So, Check All That Apply.	
□ Appendectomy (Appendix) □ Angioplasty (Heart Stents) □ Back Surgery □ Cataract □ Cardiac Pacemaker □ Cesarean Section □ Colectomy □ Cholecystectomy (Gallbladder) □ Coronary Artery Bypass □ Exploratory Lap □ Gastric Bypass □ Inguinal Hernia Repair □ Hemorrhoidectomy □ Hip Surgery	□ Hysterectomy □ Knee Surgery □ Lithotripsy □ Lumpectomy □ Mastectomy □ Meniscal Repair □ Prostatectomy (Prostate) □ Tonsillectomy □ Tubal Ligation □ TURP □ Umbilical Hernia Repair □ Other: □ Other: □ Other: □ Other: □ Other:

Have you seen any specialists since your last visit? If so, list below.	
Cardiologist (Heart):	**Nephrologist (Kidney):**
Pulmonary (Lungs):	**Gastroenterologist:**
Orthopedic (Bones):	**Pain Management:**
Endocrinologist:	**Therapist/Psychiatrist:**
Neurologist:	**Rheumatologist:**

Other:	**Other:**
Have any of your close relatives (Father, Mother, Brother, Sister, or etc …) been diagnosed with a **NEW** illness? If so, check below and specify.	
□ Diabetes ______________________________ □ Congestive Heart Failure __________________ □ Heart Attack ___________________________ □ Stroke _______________________________ □ High Blood Pressure ______________________ □ High Cholesterol ________________________ □ Other type of Heart Disease ________________ □ COPD ________________________________ □ Asthma _______________________________ □ Other type of Lung Disease _________________ □ Genetic (Hereditary) Disease ________________ □ Alzheimers/Dementia _____________________ □ Mental Illness ___________________________	□ Breast Cancer □ Ovarian Cancer □ Cervical Cancer □ Uterine Cancer □ Colon Cancer □ Prostate Cancer □ Leukemia □ Melanoma Cancer □ Kidney Cancer □ Gastric Cancer □ Other type of Cancer ___________

Social History		
Yes	No	Social/Health Habits
		Have you smoke tobacco? _____ Past _____ Present How many years? ______ Packs Per Day ____
		Do you drink alcohol? How much per day?
		Do you use recreational drugs? What type?
		Do you consume caffeine? (Coffee, Tea, Soda) How much per day?
		Do you have any dietary restrictions? What kind?
		Do you exercise? How much? Daily _____ Weekly ______ Type of exercise?

List any **NEW (Updates)** to Health Screenings & Immunizations below.			
Type	Date	Type	Date
Lung Cancer Screening (CT Scan of Lungs)		Pneumonia (PCV15, PCV, PPSV23)	
Colon Cancer Screening (Colonoscopy, Cologuard)		Tetanus (T-Dap)	
Breast Cancer Screening (Mammogram)		Influenza (Flu)	
Prostate Cancer Screening (PSA)		Shingles Vaccine	
DEXA Scan (Bone Density)		COVID Vaccine (Moderna, Pfizer, Johnson & Johnson)	
Skin Cancer		COVID Vaccine Booster	
Last Physical Exam:	**Last Vision Exam:**	**Last Dental Exam:**	

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HEALTH SCREENING QUESTIONAIRRE

DIABETIC PATIENTS ONLY			
Type	**Date of Exam**	**Where did you have it done?**	**N/A**
Annual Eye Exam			
Annual Foot Exam			
Micro Albumin (At least twice a year)			
Hemoglobin A1c (At least twice a year)			
Vitamin B12 (It take Metformin)			
Pneumococcal Vaccine			
Hepatitis B Vaccine (Proof of Immunity)			

COPD/ASTHMA PATIENTS ONLY			
Type	**Date of Exam**	**Where did you have it done?**	**N/A**
Pneumococcal Vaccine			
Influenza (Flu) Vaccine			

COMPLETE THIS SECTION IF YOU ARE 65 OR OLDER WITH MEDICARE

Name:	Date of Birth: Date:

A Checklist for Your Medicare Wellness Annual Visit.

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
□Not at all
□ Slightly
□Moderately
□Quite a bit
□Extremely

5. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
□Very heavy
□Heavy
□Moderate
□Light
□Very light

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
□Not at all
□ Slightly
□Moderately
□Quite a bit
□Extremely

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?		
7. Can you shop for groceries or clothes without help?		
8. Can you prepare your own meals?		
9. Can you do your own housework without help?		
10. Can you handle your own money without help?		
11. Do you need help eating, bathing, dressing, or getting around your home?		

3. During the past 4 weeks, how much bodily pain have you generally had?
□No pain
□Very mild pain
□Mild pain
□Moderate pain
□Severe pain

12. During the past 4 weeks, how would you rate your health in general?
□Excellent
□Very good
□Good
□Fair
□Poor

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself. □Yes, as much as I wanted
□Yes, quite a bit
□Yes, some
□Yes, a little
□No, not at all

13. How have things been going for you during the past 4 weeks?
□Very well - could hardly be better
□Pretty good
□Good and bad parts about equal
□Pretty bad
□Very bad - could hardly be worse

14. Are you having difficulties driving your car?
□Yes, often
□Sometimes
□No
□Not applicable, I do not use a car

21. Do you exercise for about 20 minutes 3 or more days a week?
□ Yes, most of the time
□Yes, some of the time
□No, I usually do not exercise this much.

15. Do you always fasten your seat belt when you are in a car?
□ Yes, usually □ Yes, sometimes □ No

22. Have you been given any information to help you with the following:

- Hazards in your house that might hurt you? □ Yes □ No
- Keeping track of your medications? □ Yes □ No

16. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or dentures					
Problems using the telephone					
Tired or fatigued					

23. How often do you have trouble taking medicines the way you have been told to take them?
□I do not have to take medicine
□ I always take them as prescribed
□Sometimes I take them as prescribed
□I seldom take them as prescribed

17. Have you fallen 2 or more times in the past year?

□ Yes □ No

24. How confident are you that you can control and manage most of your health problems?
□Very confident
□ Somewhat confident
□Not very confident
□I do not have any health problems.

18. Are you afraid of falling? □ Yes □ No	How old are you? □ 65-69 □ 70-79 □ 80 or older Are you male or female? □ Male □ Female What is your race? (check one or more than one) □White □Black/African American □Asian □Native Hawaiian/Other Pacific Islander □ American Indian/Alaskan Native □Hispanic or Latino origin or descent □Other
19. Are you a smoker? □No □Yes, and I might quit □Yes, but I'm not ready to quit	
20. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have? □ 10 or more per week □6-9 per week □2-5 per week □1 drink or less per week □No alcohol at all	

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CONSENT TO TREAT

Name: ____

Date of Birth: ____

I consent to allow the providers of the Aset Primary Care to perform necessary medical examinations and tests to diagnose and treat my health conditions. I have the right to discuss any treatment with my provider. I am encouraged to ask questions about any concerns I have.

I acknowledge that Aset Primary Care is committed to protecting the privacy and confidentiality of my personal health information in accordance with applicable laws and regulations.

This consent is valid until I revoke it in writing.

_____________________ Signature

_____________________ Today's Date

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PH 502 947-2273 Fax 502 947-2274

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

________________________ ____________ ______________
(Patient's Full Legal Name) (DOB) (Contact Phone #)
Address: ______________________ ________________

I, AUTHORIZE:

____
(Name of Hospital or Physician Practice to Disclose Information)

Disclose Information to: FAX 502 947-2274 (secured)

Recipient Name: Aset Primary Care ~ Address: 1017 Dupont Rd, Ste B ~ Louisville KY 40207

DISCLOSE THE FOLLOWING INFORMATION:

☒ I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following
☒ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, and telephone messages
☒ All physical, occupational, and rehab requests, consultations, and progress notes.
☒ I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

________________________ ______________ ______________
Signature Date Signature of Witness

If an Individual is unable to sign this Authorization, please complete the information below

______________ __________ ______ __________
Name of Guardian/ Representative Legal Relationship Date Witness