Lisa E. Medwedeff, M.D. • Gracie Martinez, APRN FNP-C . • Winona Tzou, APRN FNP-C
Legacy Medical Village ● 5425 West Spring Creek Parkway ● Suite 210 ● Plano, TX ● 75024
Phone: 972-608-3333 ● Fax: 972-473-7333 ● Website: www.villageinternalmedicinegroup.com

Physical Exam History: MALE

Today's Date: ______________________________

Name: ______________________________

Date of Birth: ______________________________

Age:__________years

Insurance Name ______________________________

Email Address: ______________________________

Family History: Please state significant disease of family members and age of diagnoses and age of death (i.e. Diabetes, high blood pressure, Cancer, heart disease, Stroke, etc…) Circle either (A-alive, D -deceased)

Father -______________________________A D

Mother -______________________________A D

Brother -______________________________A D

Sister -______________________________A D

Maternal Grandfather-______________________________A D

Maternal Grandmother-______________________________A D

Paternal Grandfather-______________________________A D

Paternal Grandmother-______________________________A D

Social History: (circle answers and/or write comments)

Occupation/Profession:____________How Long?____yrs Hrs/week: ____

Marital Status: *single, married, widowed, divorced, separated, engaged, domestic partner* Comment? ______________________________

How many children? ____________________
Their ages: boys________________ girls________________

Do you **use sunscreen**? Yes / No

Alcohol: *none / rarely / occasional / everyday* #_____drinks/week?
Preference of alcohol ______________________________

Sexually active? *Yes / No* **History > one partner**? *Yes / No*
Do you practice safe sex? *Yes / No*
Sexual Orientation: Heterosexual / Homosexual
Have you ever had sexually transmitted infection(s)? *Yes / No*
Do you want HIV/AIDS screening? Yes / No

Are you on a special **Diet**? *Yes / No*
Type: ______________________________

Exercise: *none / rarely / intermittently / regularly*____________days/ *wk* or *mo*
Aerobic___________min/day. Walk__________________min/day
Weights___________min/day. Other ________________

Weight change in last 6 months: *no change / gained / lost*
\# pounds?______. Is the reason for this change obvious to you? *Yes / No*

Comments? ______________________________

Have you ever used illegal drug(s)? *Yes / No*
If yes, what drug(s)? __________ How many years? _____years

( ) **Never smoked** ( ) **Smoked**______packs/day for______years.
I quit smoking__________years ago.
I **have** or **have not** tried to quit. If yes, what method?________________
Cigars? Yes/No **Chewing Tobacco** Yes/No **E-Cig** Yes/No

Immunizations:	Month/Year	Immunizations:	Month/Year
Tetanus (Tdap)	_______	*Covid*	_______
Pneumonia 23	_______	*Hepatitis A*	_______
Pneumonia 13	_______	*Hepatitis B*	_______
Shingle (Zostavax)	_______	*PPD (TB Skin Test)*	_______
Influenza	_______		
Gardasil/HPV	_______		

Previous Physical Exams: (circle answers and/or write comments)

Last **Physical**: date___________Was exam: *abnormal / normal*

Comment?______________________________

Last **Rectal/Prostate Exam**: Date__________________

Was exam: *abnormal / normal*

Comment______________________________

Vasectomy? Yes / No Date:____________________

Last full **blood work**: date__________Was anything abnormal? *Yes / No*

Comment______________________________

Last **chest x-ray**: date__________ Was anything abnormal? *Yes / No*

Comment______________________________

Last **EKG**: date__________________ Was: *abnormal / normal*

Last Heart **Stress Test**: date______________Was: *abnormal / normal*

Coronary Calcium Score date_________________Score__________

Last **Colon Screening** test: date:______________________________

Perform by (**Physician**)______________________________

Type: *stool card / sigmoidoscopy / colonoscopy*

Was: *abnormal / normal*

Finding (*polyps*?)____________________Repeat in____________years

Last **Bone Density**: date_______________ Was: *abnormal / normal*
Osteopenia/ Osteoporosis Facility performed at?__________________

MRI/CT scan of?________________________When?______________
Was: *abnormal / normal*

Last **Foot** Exam?: date_______

Last **Eye** Exam?: date_______

Last **Dental** Exam? date_______

Last **Sonogram** of:______________________________
(example: Thyroid, Abdominal, Carotid, Venous Doppler etc.**)**
date______________________________

Other Tests: type________________________, when? ____________

Past Medical History: Have you ever had the following? (Circle all that applies.)

ADD
AIDS/HIV
Alcoholism
Allergies/ Hay fever
Anemia
Anorexia
Anxiety
Asthma
Back pain, chronic
Breast Cancer
Other Cancer: _________
Depression
Diabetes Type I
Diabetes Type II
Diabetes, gestational
Diverticular disease
Eczema/ Hives
Emphysema
Erectile dysfunction
Fibromyalgia
Gallbladder/Stones
Genital herpes
Glaucoma
Heart Attack
Heart disease
Hemorrhoids
Hepatitis
Hernia
High cholesterol
High blood pressure
Irritable bowel
Kidney stones/disease
Liver Disease
Migraine
Mitral valve prolapse
Obesity
Osteoporosis/ Osteopenia
Pneumonia
Prostate enlargement/ Cancer
Reflux
Rheumatic Fever
Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disease
Tobacco use
Tuberculosis
Ulcer
Venereal Disease

Health Problems in Last 6 Months: (circle and/or write comments)

Y N **Problems with urinary tract (kidney, ureters, bladder)?**

Y N **Loss of control of your bladder?** *Date began?* ___________

Y N **Pain or burning with urination?** *Currently? Yes / No*

Y N **Frequent urination?** *Currently? Yes / No Date it began*_____________

Y N **Do you have to push or strain to start urination?**

*Date began*_____________

Y N **Enlarged or Abnormal Prostate?** *Date found?*________________.

*Comment*____

Y N **History of Acute or Chronic Prostatitis?** *Currently? Yes / No Date began?*________________*Treated by a Doctor? Yes / No*

Y N **Pain in Penis, Testicles, or Scrotom?** *Date began*_______________

Y N **Lump in Penis, Testicles, or Scrotom?**

Y N **Decreased ability to have an erection?**

*Date first noted*_______

Y N **Pain with Intercourse?** *If currently, Date it began*_________________

Y N **Previous history of sexual transmitted disease?**

*Type?*__________. *When discovered*___________. *Treated? Y/N*

Y N **Rectal Pain or Rectal Bleeding?** *Currently? Yes / No Has this been addressed by a doctor? Yes / No*

Y N **Hemorrhoids? Currently?** Yes/ No
Has this been addressed by a doctor? Yes / No

Please give your reason(s) for coming in today or health concerns that you want addressed:

____

____

Allergies to Medication: (give name of medication and type of reaction, for example, upset stomach, rash, respiratory distress.
Example: *Penicillin – hives, swelling and joint pain)*

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________

Medical Problems / (Past Diagnosis) :
(Asthma, Diabetes, High Blood Pressure, Reflux, High Cholesterol, Allergies, Arthritis, etc…)

1.________________date began______
2.________________date began______
3.________________date began______
4.________________date began______
5.________________date began______
6.________________date began______
7.________________date began______
8.________________date began______
9.________________date began______

Operations: (gallbladder, hysterectomy, appendix, hernia, vasectomy, mastectomy, polypectomy, etc…)

1.________________date______
2.________________date______
3.________________date______
4.________________date______
5.________________date______
6.________________date______
7.________________date______
8.________________date______
9.________________date______
10.________________date______

Current Medications: (Name, Dosage, How often)

(ex. Benicar HCT 40mg- 12.5mg 1 pill twice daily)

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________
11.____________________

Hospitalizations: (give reason and month/year)

Reason Mo/Yr

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________
11.

Review of Systems:

Circle all that apply to you, include onset date, current status, and severity

- General:
  Sense of well-being: Good / Poor
  Energy Level: Good / Poor
  Fever – Chills – Night Sweats – Swollen Glands – Weight Loss – Weight Gain – Change in Sleep
- Skin:
  Acne – Changing Moles – Lumps – Rashes – Eczema – Psoriasis – Skin Lesions
- Eyes:
  Blurred/Double Vision – Pain
- Ears:
  Decreased Hearing – Ringing – Change in Hearing – Hearing Aids
- Nose:
  Bleeding – Polyps – Deviated Septum – Sinus – Allergies
- Throat/Mouth:
  Swollen Glands – Canker Sores – Dry Mouth – Dentures – Snoring
- Pulmonary:
  Wheezing – Short of Breath – Cough
- Heart:
  Chest Pain – Rapid / Irregular / Skipped Heartbeats – Decreased ability to exercise – Swollen Ankles – Leg pain when walking – Short of breath
- GI:
  Nausea – Indigestion – Vomiting – Diarrhea – Cramps – Constipation – Hemorrhoids – Change in Appetite –
  Increased Gas / Bloating – Bloody / Black Stools –Abdominal Pain– Mucous in Stools
- GU:
  Painful Urination – Frequent Infections – Bloody Urine – Difficulty Starting / Stopping Stream – Leakage – Excessive Night Urination (# times/night______) –
  Prostate Problems – Genital Lesions – Discharge – Sexual Dysfunction – Dribbling with Urination – Hard Testicle – Hernia – Penile Discharge
  Rash or Blisters on Penis – Scrotal Pain
- Endocrine:
  Heat / Cold Intolerance – Excessive Thirst – Excessive Urination – Excessive Dry / Oily Skin – Excessive Hair Growth / Loss
- Hematology:
  Easy Bruising / Bleeding – Clotting Disorder – History of Transfusion
- Neuro: Headaches (# per month_______________)
  Changes in Smell/Taste – Changes in Behavior – Changes in Vision– Dizziness
- Psych:
  Feeling Helpless / Hopeless – Anxious – Irritable – Emotional – Depressed – Thoughts of Suicide or Death
- Musculo-Skeletal:
  Muscle Aches/Cramps – Swollen Joints – Tender Joints
- Hematology:
  Clotting Disorder – Easy Bruising / Bleeding – History of Transfusion

Do you have any other physicians?

Allergist:________________________ Neurologist: ________________________ Psychiatrist: _________________________

Cardiologist: ____________________ ENT: ______________________________ Pulmonogist: ________________________

Chiropractor: ____________________ Rheumatologist: _____________________ Urologist: ___________________________

Dermatologist: ___________________ Ophthalmologist:_____________________ General Surgeon: ____________________

Dentist: ________________________ Orthopedic Surgeon: __________________ Other: ___________________________

Endocrinologist: _________________ Pain Management: ____________________

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EXPLANATION OF COMPLETE PHYSICAL EXAM

A physical exam is a critical part of your healthcare provided by Village IMG. The frequency of the exam is determined by Village IMG, based on your age and overall health.

Insurance plans, as determined by your policy or your employer, have vastly different benefits for routine exams. In some cases, insurance will not cover routine care at all (or “well patient” or “preventative care” office visits.)

Prior to your visit, we encourage you to contact your insurance company to see what benefits are included for a routine physical exam (to include lab work, mammogram, chest x-ray, EKG, PFT, stress test.) Benefits may be different if performed at another location.

_________ *(initial here)* ***If you are scheduled for a routine physical and wish to address issues outside of routine care, insurance may or may not cover charges for additional consultation and non-covered charges will be billed to you. In some cases, insurance companies would rather you return on another day to discuss your on-going health concerns.***

These are the directives of insurance companies, not our office. We simply want you to be informed and know your potential financial exposure for non-covered benefits as well as make you aware of the possible need for multiple appointments.

PLEASE SIGN THE WAIVER BELOW FOR POSSIBLE NON-COVERAGE OF SERVICES.

I understand my insurance company may or may not fully cover routine/preventative care services performed in and outside of our office, as ordered by Dr. Medwedeff, as part of my complete physical exam. I acknowledge this and understand it is my responsibility to understand the application of my benefits in this situation. I understand that I am responsible for a charges not covered by my insurance company.

___________________________________ ______________
Signature of Patient Date

PATIENT INFORMATION AND NOTIFICATION

I would like to ask you to take a few minutes to read over the policies and procedures we have chosen to operate Village IMG. Please help us by understanding there are many unique considerations and aspects of the solo primary care medical practice. We need to implement guidelines in order to continue to provide quality patient care and protect the ability to continue as a solo practice. By working together, we can establish strong patient relationships that can remain autonomous while meeting patients' needs with the highest degree of excellence. Without some basic standards of operation, we will certainly be taken under by a healthcare system that is working against us. By reading and signing below, you are stating that you have been provided and understand our office policies and procedures put in place to ensure our ability to provide the best levels of service and care for our patients.

Thank you in advance for your understanding and cooperation.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping patient information private is important to us. Our policy is to only disclose patient information (billing and medical condition), to the patient or legal guardian. This includes a spouse or adult child who you might want Village IMG to discuss medical findings with or involve in your treatment plan. If there are additional people whom you would like to have access to this information, please fill out the form provided in this packet.

WRITTEN CORRESPONDENCE

We can only provide written correspondence in three ways: via the patient portal, US Mail, or in person. We cannot provide statements, test results, or other medical information through e-mail.

INSURANCE

Even though this information is stored in our computer system, insurance changes frequently and we need to be absolutely sure we have your latest coverage updated and that we file correctly. Please be prepared to show us your insurance information on each visit.

Healthcare Insurance can be confusing. Keep in mind the following:
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- We are only contracted with select insurance plans. Contact your insurance carrier to confirm Dr. Medwedeff or Dr. Wills is a "preferred provider" or "in network."
- We will contact your insurance carrier for benefits; however, it is your responsibility to know your benefits and coverage.
- We will submit your insurance claims on your behalf.
- After filing with your insurance there are several possible outcomes:
  - The claim will be paid and you will receive a statement for the portion your contract allows but does not pay in full.
  - All or part of the claim may be applied to your deductible and you will be responsible for the balance.
  - They may deny the claim. If this happens: You will need to contact your insurance carrier (not our office) for the denial reason and what, if anything, can be done to get the claim paid. Once you do this, let us know, and we will resubmit the claim. If it is still denied, you will be responsible for all allowed charges.

Texas law now requires commercial insurance carriers to pay medical claims within 45 days. If they do not, it will then be your responsibility to pay the professional services in full. Should we receive a subsequent payment from your insurance carrier, we will provide a refund by check or a refund your credit card.

SCHEDULING

Excellent medical care takes time to diagnose and treat. Sometimes our schedule is delayed when patients require more attention than originally anticipated. We ask for your patience in waiting, realizing that you will receive the same high level of care.

ANNUAL PHYSICALS / GYN EXAMS

If you advise that you're coming in for a physical or a Gynecological (GYN) exam, we will bill the office visit and lab as "routine wellness". If your plan does not cover these services, you will have to pay in full. If you require services beyond "routine wellness" at the same time, an additional office visit charge will be added.

LATE ARRIVALS/NO SHOW

- The first appointment in the morning and afternoon are reserved for individuals who have tight schedules and need to be seen promptly. We have a zero tolerance for late arrivals for these choice times.
- All appointments need to be rescheduled if you're running more than 15 minutes late unless we have had a cancellation and can accommodate your visit into our schedule.
- Patients more than 20 minutes late will be considered a no-show and an appropriate charge will be assessed.
- If you "no show" for three appointments, written notice will be sent to you terminating you as a patient.

CANCELLATIONS

Please provide us with 24 hours advance notice if you need to reschedule an appointment. This can be done via phone or patient portal. Failure to do so will incur the following charges based on the amount of time previously reserved:

- 15 – 25 minute appointments $25.00
- Physical/GYN exam $50.00
- Procedure visit such as minor surgery or diagnostic testing $75.00

LAB

Our electronic health records (EHR) are interfaced with Clinical Pathology Laboratory (CPL) and Quest. For this reason, these are our preferred laboratories.

PATIENT PORTAL

You have partial access to your medical records via the secure patient portal. You can review all documented diagnosis, medications, medication allergies, and most test results. Messages can be sent and will be addressed within 48 hours (during regular business hours.) All non-emergency communication should take place via the patient portal as opposed to email or phone calls

STATEMENTS

- Statements are due upon receipt.
- Late fees (1.5% total due) may be added if payment has not been received within 30 days from the date of the statement.
- Payments due for more than 90 days are subject to collection.
- Payments may be made at any time via phone with Visa or MasterCard.

ADDITIONAL ITEMS:

- Health forms to be completed (outside of office visits) will have a charge of $25.00 per page.
- Letters requested of Dr. Medwedeff will be charged based on complexity and time, starting at $40.00.
- Copies of medical records are charged according to the Texas Medical Examiners fee schedule which is $25 for the first 20 pages and $0.50 per page thereafter.
- Letters mailed at patient's request are $1.00.

I have read and understand the above policy and procedure:

____

Patient Signature

____

Today's Date

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services that Village IMG creates and maintains health records describing among other things my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging medical review, legal services, auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I have listed below the names of others that may have access to my personal health information. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral, or electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or healthcare operations without prior written authorization, except as otherwise provided by the law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

PRIVACY DISCLOSURE OF MEDICAL INFORMATION
(circle YES or NO)

I approve the receipt of a FAX with medical information: YES or NO

I approve the receipt of an E-MAIL with medical information: YES or NO

I approve the receipt of a TEXT MESSAGE with medical information: YES or NO

I approve the receipt of a VOICEMAIL with medical information: YES or NO

____________________________________ ____________________
Printed Name of Patient Date of Birth

____________________________________ ____________________
Patient Signature Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

____ ____________________
Patient Name Date of Birth

I, the above mentioned, release the following medical information:

_____ All medical records

_____ All billing records

Information can be released and sent to the following people authorized to receive information:

____ ____________________
Name Relationship

____ ____________________
Name Relationship

____ ____________________
Name Relationship

I, the above mentioned, release Village Internal Medicine Group, and the staff, from any liability concerning my medical records.

____ ____________________
Patient Signature Date