

**Mary's Family Medicine  
Dr. Gina Landicho-Wicks  
16701 Cleveland Street, Suite 210  
Redmond, WA 98052**

Thank you for scheduling a physical exam at Mary's Family Medicine.  
*Please arrive on time to insure adequate time for your exam!*

If you have a morning appointment, please do not eat breakfast prior to your appointment (water and black tea or coffee is okay). Screening blood tests will probably be needed and will be drawn at the lab on the day of your appointment. If you have an afternoon appointment, you may eat prior to your appointment, if you wish. Blood tests may be drawn at that time or may be recommended at a later date with fasting. Remember to drink plenty of water whenever having a blood draw, to help make your blood draw easier.

The purpose of a complete physical exam is to recheck known, ongoing medical problems; to screen for unknown disease; to assess a person's risk of future disease and to discuss ways to prevent future illness and disease. **There will not be sufficient time during your visit to discuss multiple new medical issues.** If you have more than one new medical issue that needs to be addressed, please make a separate appointment to have these addressed. If you feel the issue(s) cannot wait, then a separate appointment is needed sooner; talk to our receptionist to schedule one as soon as possible.

Complete the adult health questionnaire and risk assessment forms enclosed. This information will update your health records and help Dr. Gina focus on important risk factors and issues. Please bring the completed forms with you as well as your current vaccine records (if available) when you come in for your exam. When your exam is complete, we will have enough information to assist you in better understanding your present level of health and how lifestyle decisions affect your risk of present and future disease. Hopefully, this will be an aid to you in making long-term decisions to improve your immediate and future health.

**Please verify with your insurance BEFORE your exam for coverage of your physical exam. You are responsible for any payments not covered by your insurance plan.** Note that some insurances will cover some/all of the costs, others will cover a maximum dollar amount, some only every 1, 2 or 3 years and others will not cover any of the costs of a preventative care exam.  
\* \* Please bring your current medical insurance card to your appointment. \* \*

Call our office at (425) 883-8050 for cancellations or questions.

*We require 24 hours advance notice if you need to cancel your appointment.*

# Adult Health Questionnaire -

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_  
 Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Marital Status - S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_ Religion \_\_\_\_\_  
 Occupation \_\_\_\_\_ Previous M.D. \_\_\_\_\_ Location \_\_\_\_\_  
 Do you smoke or chew tobacco? Y \_\_\_/N \_\_\_ Do you exercise regularly? Y \_\_\_/N \_\_\_

## Past Medical History

Past, ongoing or recurrent medical problems

Past Surgeries/ Hospitalizations

Diagnosis	Year diagnosed	Diagnosis	Year

Women: Number of pregnancies \_\_\_\_\_ / Number of live births \_\_\_\_\_ / Number of miscarriages \_\_\_\_\_  
 Birth control method \_\_\_\_\_ Menopause? Yes \_\_\_\_\_ / No \_\_\_\_\_ / Year \_\_\_\_\_

### Immunizations

	Y/N	Year
Pneumonia vaccine	___/___	_____
Influenza vaccine	___/___	_____
Hepatitis B	___/___	_____
Tetanus (last)	___/___	_____
Standard childhood immunizations	___/___	_____

### Past Infections

	Y/N
Chickenpox	___/___
Tuberculosis	___/___
Rheumatic fever	___/___
Hepatitis	___/___
Pneumonia	___/___
Pelvic infection	___/___

### Past Exams

	Y/N	Year
Eye exam	___/___	_____
PSA	___/___	_____
Mammogram	___/___	_____
PAP smear	___/___	_____
Exercise treadmill	___/___	_____
Stool for blood	___/___	_____
Sigmoidoscopy	___/___	_____

### Medication Reactions/Allergies

Medication	Reaction	Medication	Reaction

## Family History of Disease

### Immediate family

	Age	Diseases
Father	_____	_____
Mother	_____	_____
Bro/Sis	_____	_____
/	_____	_____
/	_____	_____
/	_____	_____
/	_____	_____

Check below if any blood relatives have had the following problems:

(Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U, Cousin-C)

Diabetes Y ___/N ___ / Relation _____	Heart disease Y ___/N ___ / Relation _____
Stroke Y ___/N ___ / Relation _____	Hypertension Y ___/N ___ / Relation _____
Cancer Y ___/N ___ / Relation _____	Tuberculosis Y ___/N ___ / Relation _____
Epilepsy Y ___/N ___ / Relation _____	Arthritis Y ___/N ___ / Relation _____
Thyroid Y ___/N ___ / Relation _____	Alcoholism Y ___/N ___ / Relation _____
Bleeding Y ___/N ___ / Relation _____	Colon cancer Y ___/N ___ / Relation _____
Kidney Y ___/N ___ / Relation _____	Mental illness Y ___/N ___ / Relation _____
Other _____	

Continued on other side

**Current medications:**

Medication	Dose (strength)	Frequency	Reason Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Nutritional / Herbal supplements:** \_\_\_\_\_

**Social history:** Number of children \_\_\_\_\_. Method of contraception \_\_\_\_\_. If using tobacco, # of times used per day \_\_\_ or week \_\_\_\_\_. Exercise- days per week \_\_\_\_\_. Caffeine drinks per day \_\_\_ or week \_\_\_\_\_. Alcoholic drinks per day \_\_\_ or week \_\_\_\_\_. Do you consider your present diet high \_\_\_\_, moderate \_\_\_\_ or low \_\_\_\_ in fat. Has anyone asked you to cut down on your drinking? Y \_\_\_\_, N \_\_\_\_.

**Systems Review:** Have you been bothered a significant amount by any of the problems below presently or in the past? (Mark ✓ for current or ongoing problems, a X for past problems)

**General:**

Constant fatigue Y \_\_\_/N \_\_\_  
 Anemia Y \_\_\_/N \_\_\_

**Eyes:**

Decreased vision Y \_\_\_/N \_\_\_  
 Glasses/contacts Y \_\_\_/N \_\_\_  
 Glaucoma Y \_\_\_/N \_\_\_

**Ears:**

Hearing loss Y \_\_\_/N \_\_\_  
 Recurrent ear infections Y \_\_\_/N \_\_\_  
 Ringing in ears Y \_\_\_/N \_\_\_

**Head:**

Frequent headaches Y \_\_\_/N \_\_\_  
 Dizziness Y \_\_\_/N \_\_\_

**Nose/Throat:**

Hayfever Y \_\_\_/N \_\_\_  
 Recurrent sinus infections Y \_\_\_/N \_\_\_  
 Severe snoring Y \_\_\_/N \_\_\_

**Skin:**

Changing moles Y \_\_\_/N \_\_\_  
 Chronic rash Y \_\_\_/N \_\_\_  
 Skin growths Y \_\_\_/N \_\_\_

**Heart:**

Shortness of breath Y \_\_\_/N \_\_\_  
 Chest pain Y \_\_\_/N \_\_\_  
 Palpitations Y \_\_\_/N \_\_\_  
 Murmur Y \_\_\_/N \_\_\_

**Lungs:**

Wheezing/asthma Y \_\_\_/N \_\_\_  
 Chronic cough Y \_\_\_/N \_\_\_  
 Coughing up blood Y \_\_\_/N \_\_\_

**Stomach:**

Frequent pain or heart burn Y \_\_\_/N \_\_\_  
 Recurrent diarrhea Y \_\_\_/N \_\_\_  
 Blood in the stool Y \_\_\_/N \_\_\_  
 Hemorrhoids Y \_\_\_/N \_\_\_

**Urinary:**

Decreased flow or control Y \_\_\_/N \_\_\_  
 Painful or frequent urination Y \_\_\_/N \_\_\_  
 Blood in the urine Y \_\_\_/N \_\_\_  
 Kidney stones Y \_\_\_/N \_\_\_

**Musculo-skeletal:**

Joint pain or swelling Y \_\_\_/N \_\_\_  
 Arthritis / gout Y \_\_\_/N \_\_\_

**Nervous system:**

Convulsions Y \_\_\_/N \_\_\_  
 Fainting spells Y \_\_\_/N \_\_\_

**Genital:**

Sexual diseases Y \_\_\_/N \_\_\_  
 Vaginal/penile discharge Y \_\_\_/N \_\_\_  
 Sexual problems Y \_\_\_/N \_\_\_

**Menstrual:**

Heavy or painful periods Y \_\_\_/N \_\_\_  
 Abnormal PAP smear in past Y \_\_\_/N \_\_\_

**Mental health:**

Excessive worry or anxiety Y \_\_\_/N \_\_\_  
 Excessive moodiness or depression Y \_\_\_/N \_\_\_  
 Alcohol or chemical dependency Y \_\_\_/N \_\_\_

**Additional questions for your provider:** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

## Risk Assessment Form - Men

Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

This form is designed to provide you and your medical care provider with information about your risks for common illnesses. If you have any questions about these illnesses ask your medical provider. Please check any that apply to you.

### The following risk factors are associated with Skin Cancer:

- |   |   |
|---|---|
| <input type="checkbox"/> Sun tanning (natural or tanning booth) | <input type="checkbox"/> Prior history of atypical moles, large sized birthmarks or xeroderma pigmentosum |
| <input type="checkbox"/> Family history of melanoma             |   |
| <input type="checkbox"/> Prior history of skin cancer           |   |

### The following risk factors are associated with Heart Attack and Stroke:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Smoking             | <input type="checkbox"/> No regular exercise | <input type="checkbox"/> Family history or heart attacks or strokes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High fat diet       |   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High cholesterol    |   |

### The following risk factors are associated with Lung Cancer:

- |                                  |  |
|----------------------------------|--|
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Asbestos exposure |
|----------------------------------|--|

### The following risk factors are associated with Colon Cancer:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Smoking        | <input type="checkbox"/> Family history of colorectal cancer or polyps | <input type="checkbox"/> Crohn's disease or ulcerative colitis |
| <input type="checkbox"/> High fat diet  |  | <input type="checkbox"/> Previous cancer of the colon          |
| <input type="checkbox"/> Low fiber diet |  |  |

### The following risk factors are associated with Accidents:

- No smoke alarm at home
- Not wearing seat belts while driving
- History of driving while intoxicated
- A gun in the house that is stored already loaded

### The following risk factors are associated with Prostate Cancer:

- Family history of prostate cancer
- African-American ethnicity
- High fat diet

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### Handouts given:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetic Education        | <input type="checkbox"/> Stop Smoking                    | <input type="checkbox"/> Prostate Cancer   |
| <input type="checkbox"/> Low-fat Diet              | <input type="checkbox"/> Skin Cancer, Signs and Symptoms | <input type="checkbox"/> Diet and Cancer   |
| <input type="checkbox"/> Cholesterol/Triglycerides | <input type="checkbox"/> Colon Cancer                    | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Managing Hypertension     |  |  |

Date: \_\_\_\_\_

\_\_\_\_\_  
Nurse Signature

\_\_\_\_\_  
Provider Signature