Health ONE Aspen Medical Group
Physician Care℠

Crista Keller, M.D.
Megan Press, M.D.
Katherine Johnson, NP-C
Megan Watanabe, NP-C
E. Kendrick Lane, PA-C

Important – Please Read

Most insurance plans offer a preventive exam for a reduced copayment or no copayment. This is a quick reference designed to help you understand which services are typically covered under your preventive benefit and which services are not. Please be aware that if you receive care beyond what your preventive benefit covers, you may incur additional charges for the care provided.

Services covered during your preventive visit:

- Age/Gender-focused exam
- Advice for disease prevention and healthy living
- Discussions about previously identified risk factors (i.e. smoking)
- Certain Lab/X-ray tests to screen for diseases for which you may be at risk due to age, gender or lifestyle
- Standard age-based immunizations
- Management of previously diagnosed chronic problems that are relatively stable
- Management of minor new problems that require no new lab tests, procedures, follow up, or prolonged treatment plans.

Services **not** covered during your preventive visit* which are subject to additional charges:

- New problems requiring lab tests, x-ray, or other evaluation
- New problems requiring prescription medication
- Chronic problems which are not controlled and which require evaluation, management, and/or changes in medications
- Immunizations specific for travel.

*Please note that this handout is a guide only and does not describe or completely define your preventive benefit. In the event of a discrepancy between this document and your Evidence of Coverage (EOC) or Membership Agreement, please defer to your EOC or Membership Agreement, as it takes precedence over this handout. If you have specific questions on your preventive benefit, and what services are covered, please call the member services phone number on your insurance card.

Wishing you the best of health, the staff of Aspen Medical Group

I acknowledge that I have read and understand the information provided above.

Printed Name: _____ DOB _____
Signature: _____ Date _____

Current Patient Medical History

Name: _____ **Date of Birth:** _____

Issue(s) you wish to discuss today: _____

Allergies: _____

List medications and dose you are on:(□See Attached List)

Have you had any of the following health problems? Check all that apply. □None apply

□ Heart attack	□ Asthma	□ Back problems	□ Bleeding/clotting	□ Arthritis
□ Heart disease	□ Emphysema	□ Diabetes	□ Anemia	□ Migraines
□ Chest pain	□ Stroke	□ Mental Illness	□ AIDS/HIV	□ Cancer. Type:_____
□ High blood pressure	□ Seizures	□ Thyroid problems	□ Reflux disease	□ Other: _____

Please list any surgeries you have had including dates: _____

Has anyone in your family had the following health problems? Check all that apply and list relationship. □None apply

□ High blood pressure_____	□ Diabetes_____	□ Bleeding Disorder_____
□ Heart disease_____	□ Asthma_____	□ Cancer, Type_____
□ Thyroid problems_____	□ Arthritis/Joint pain_____	□ Other:_____
□ Stroke_____	□ Metal Illness_____	□ _____

Have you ever smoked? No Yes **Do you smoke now?** No Yes - if yes, _____packs per day for the last _____years
Alcohol use? ____drinks per □day □week □month **Recreational drug use? (**circle) Yes No Type(s): _____
What is your occupation? _____ **Exercise Routine:**_____

Relationship Status: married single divorced widow(er) **Sexual Identity:**_____

Have you had any of the following in the last month: (Mark with an X)

General
- □ No problems
- □ Fever
- □ Weight loss
- □ Weight gain
- □ Night sweats

Ears
- □ No problems
- □ Hearing loss
- □ Ear pain

Nose
- □ No problems
- □ Congestion/Obstruction
- □ Post nasal drip

Throat
- □ No problems
- □ Sore throat
- □ Difficulty swallowing

Pulmonary
- □ No problems
- □ Wheezing
- □ Coughing
- □ Shortness of breath

Gastrointestinal
- □ Nausea/vomiting
- □ Heartburn
- □ Abdominal pain
- □ Constipation/Diarrhea
- □ Blood in stool

Musculoskeletal
- □ No problems
- □ Joint/Back pain
- □ Muscle weakness
- □ Balance issues

Genitourinary
- □ No problems
- □ Painful urination
- □ Frequent urination
- □ Blood in urine
- □ Incontinence

Cardiovascular
- □ No problems
- □ Chest pain
- □ Swollen ankles
- □ Palpitations

Neurological
- □ No problems
- □ Numbness/weakness
- □ Tingling
- □ Dizziness
- □ Memory loss

Psych
- □ No problems
- □ Depression/anxiety
- □ Insomnia

Hematology/Endo
- □ No problems
- □ Anemia
- □ Bleeding tendency
- □ Heat/cold intolerance

Skin
- □ No problems
- □ Skin lesions
- □ Pigmentation changes

Eyes
- □ No problems
- □ Change in vision

Women
- □ Changing periods
- □ Other concerns

Men
- □ Erectile dysfunction

Please list any other medical providers you see: _____
Do you have an Advanced Directive Yes No
Advanced Care Planning Consent: I consent to discuss end-of-life planning issues with my healthcare provider (circle) Yes No
Please provide month and year you most recently had the following:
Mammogram:_____ Colonoscopy:_____ Bone Density:_____ Pap Smear:_____
Eye Exam:_____ Dental Exam:_____ Dermatology Exam:_____ Tetanus Booster (tdap) :_____

Signature:_____ Date: _____