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New Patient Welcome Packet
Adult

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Greetings,

Welcome to Orchid Health! Our Medical Clinics were founded several years ago with the belief that our state's rural communities deserve to have accessible, high quality healthcare that is local, comprehensive, and takes the time to address what matters most to you.

Your care team will include your:

Primary Care Provider (PCP): Your PCP will help you think through important health decisions and may connect you with another member of the care team to make sure that you are getting the best care.

Behavioral Health Consultant: Our Behavioral Health Consultant is available to help with any mental, emotional, or behavioral health needs that you may have. This may include making lifestyle changes, dealing with sadness or loneliness, or problems at home or school.

Medical Assistant: Your Medical Assistant will be the first person you talk with when you have a health concern and will work closely with your PCP and BHC to help support ongoing care both in and out of the clinic as needed.

Enclosed are our patient registration forms. Please complete these forms to the best of your knowledge. Included is a Medical Records Release form, which allows us to request your past medical records prior to your first visit. We ask that you complete this form and mail it back to us or drop it off at our clinic as soon as possible. This will allow our providers to best prepare for your visit.

Additionally, a Controlled Substance Agreement, must be signed before the prescription of controlled substances by Orchid Health providers. This form can be found on the last page of this packet.

In order for us to best serve you:

1. Please check in at the clinic fifteen minutes prior to your scheduled appointment time.
2. Please bring the bottles of any current medications you are taking.
3. Please bring your insurance card and your ID with you to your visit.
4. If you need to cancel or reschedule your visit please provide us with 24 hours notice.

In Oakridge:

- We are located on Highway 58, right near the Pharmacy.
- Our hours of operation are: Monday, Tuesday, and Wednesday from 8am to 7pm and Thursday and Friday 8am to 5pm. For after hours support, call our main clinic # 541-782-8304.

In Estacada:

- We are located on the High School Campus, just to the right of the Estacada High School.
- Our hours of operation are: Monday and Tuesday 8am to 7pm and Wednesday, Thursday and Friday 8am to 5pm. For after hours support, call our main clinic # 503-630-8550.

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ESTACADA Clinic 503-630-8550
OAKRIDGE Clinic 541-782-8304

FAQ - Frequently Asked Questions!

How do I make an appointment?

- Most people call our office to schedule an appointment - the numbers are listed above.
- If you know that you need a future appt, we love it when you schedule before you leave the office.
- You can also request an appointment through our Patient Portal.

What is the Patient Portal?

- The Portal allows you to send messages directly to the Medical Assistants or Providers, instead of calling. It is easy to use if you can find a way to get on the internet (try the library!).
- You can find the portal link on our website: **www.orchidhealth.org** (upper right corner).
- Ask any of our staff for help. We can send you an email link or set you up when you come in.

What days and hours are you open?

- *Oakridge:* Monday, Tuesday, and Wednesday 8-7, Thursday and Friday 8-5
- *Estacada*: Monday, Tuesday, from 8-7, Wednesday, Thursday, and Friday from 8-5

What if I need to reach someone after the office is closed?

- Easy! Use the same phone number you normally call (at the top of this page) - and listen for the option to reach our After Hours RN Service.

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How do I get my Prescription Refilled?

- The best FIRST step is to call your pharmacy and ask them for a refill - they will then contact us directly if needed.
- If you are having any difficulty, please call us so we can resolve it for you. (Or use the portal!)
- Any "controlled medication RX" needs to be given during an appointment. (This would include things like pain medication, certain anxiety or sleep medication, etc).

Can I have my blood tests drawn at Orchid?

- Yes, we draw labs for the patients who have *established* with us (even if ordered by others).

Do you do X-RAYS at Orchid?

- No, sorry, at this time, we do not have an X-RAY machine at any of our sites - but we can give you an order to do your test somewhere else.

How can I get my lab or X-RAY/imaging results?

- If you have a follow up appointment scheduled, then your provider is probably planning to review your lab results at that time, but we will call you with anything really important so nothing gets overlooked.
- If you are expecting a ***routine*** result and do not hear from us within 7 days, please let us know, in case there was a glitch in the lab system. We want you to have your results!
- If you are expecting results from an ***urgent*** test, we will usually let you know as soon as we have the result available - often the *same* day or the *next* day

□ □ □ □

What if I am worried about paying for my visit or labs?

- We don't want money to stand in the way of Health Care, so please talk to us about your concerns.
- Ask about our Sliding Fee Discount, too.

Do you see Kids? What about Babies? What about Seniors?

- Yes, Yes, and Yes!

Orchid Oakridge Clinic
47815 HWY 58
Oakridge, OR 97463
541-782-8304

Orchid Estacada Clinic
535 NE 6th Ave
Estacada, OR 97023
503-630-8550

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Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date: 08/01/2017

This Notice of Privacy Practices applies to the following organizations.

Orchid Health

Privacy Official and Contact Person:
Melissa McDermott, Director of Operations
503-630-8550

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PATIENT RIGHTS AND RESPONSIBILITIES

Our goal is to provide the HIGHEST QUALITY of care for our patients. We respect and value you, and have created this document to help you understand what to expect from us, and what we expect from you.

You Have the Right To:

- Exercise these rights without regard to sex, age, economic status, educational background, race, color, religion, national origin, sexual orientation, gender identity, marital status, or the source of payment for care.
- Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand.
- Have privacy during care discussion, counseling & treatment.
- Personally review your medical records in the presence of a healthcare professional.
- Know the name and qualifications of staff providing your care.
- Know your diagnosis, health problems, test results, the potential advantages and risks of treatment, procedures, and medications in language you can understand.
- Expect that all services, treatment and counseling techniques will take place with your informed consent.
- File a complaint regarding any aspect of Orchid Health. Those who file complaints will be free from retribution.
- Have another individual present in the exam room with you, if you so desire.
- Request that another Orchid provider administer your care.
- Be treated from a culturally appropriate perspective.
- Receive quality medical care from a qualified provider.

You Have the Responsibility To:

- Treat Orchid staff with consideration, respect and dignity. Threats to any staff member will result in immediate termination of your care.
- Understand that your lifestyle does affect your health and take an active part in your health care.
- Follow the agreed upon treatment plan. If you choose not to follow or are unable to follow the treatment plan, it is your responsibility to inform your medical provider.
- Provide accurate and complete personal contact and insurance information as well as information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your health care.
- Communicate with your provider so that you understand a medical course of action and what is expected of you during the course of treatment.
- Observe Policies and Procedures that are for the safety and consideration of all patients and staff such as:
    - Request Prescription (Rx) refills in a timely manner. Contact your pharmacy, mail order pharmacy, or our office no less than 72 hours before your Rx is due to be filled.
    - Schedule appointments for CONTROLLED Prescriptions one week in advance
    - Arrive 15 minutes prior to your scheduled appointment time.
    - Call to cancel/ reschedule your appointments 24 hours in advance if needed.
    - Have proof of insurance and if applicable, your copayment, at the time of your appointment

_____	_____	_____
Full Name	Signature	Date

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CONSENT FORM

Consent for Treatment: I consent to medical treatment of medical services performed or prescribed by the attending or the consulting medical providers at Orchid Health, and I agree to the performance of treatments or procedures which are considered necessary, routine, or advisable. An example of some treatments performed at Orchid:

- Routine physical exams, including sports physicals
- Early detection, diagnosis and treatment of illness and injury treatment of minor injuries
- Assessment and management of chronic health conditions
- Age appropriate reproductive health
- Routine lab tests and Immunizations
- Health education, counseling, and wellness promotion
- Prescription medications if appropriate
- Behavioral health services
- Referral for health care services not provided by Orchid Health

Authorization of Payment: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive. I also authorize release of any medical records necessary to allow the insurance company to pay for these services, within the guidelines of the HIPAA (Privacy) Laws. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. If I do not have an active insurance, I agree to pay for services at the time they are received.

Notice of Privacy Practices: I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice is provided the first time I receive services from Orchid Health and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities: I acknowledge receipt of Orchid Health's Patient Rights and Responsibilities, and I agree to abide by these guidelines. This form can be found on our website under patient forms, and is available at the clinic upon check-in.

Consent to Access Historical Prescription/Pharmacy Records, and to Reach out to local Hospital Networks to Access Health History Information: I authorize the release of my historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

Consent to Call and Text I consent to receive calls and/or texts from Orchid Health for my protected healthcare and other services at the phone number(s) provided to the practice, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Patient or Authorized Representative Name (Please print) _____

If authorized representative please state relationship to patient _____

Signature _____ Date _____

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ORCHID HEALTH REGISTRATION FORM

(Please print)

Name: _____ Today's Date: _____
First - Middle - Last

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name: _____

Previous Name: _____ Legal Sex: Male/Female/Other

Date of Birth (mm/dd/yy):_____Social Security Number: _____

Mothers Maiden Name:_____

Mailing Address: _____ ZIP Code: _____ City: _____ State: _____

Home Phone: _____Mobile Phone: _____ Consent to text? Y/N Work Phone:_____

Email: _____Preferred communication method: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Current Medical Provider/Primary Care:_____

Preferred Language: _____

Race: (You can choose more than one if appropriate) ☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Hispanic or Latino Origin

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Other _____

Emergency Contact:_____ Phone Number:_____

INSURANCE INFORMATION

(please bring your insurance card to our receptionist)

Please indicate primary insurance type: _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

PERSON Financially Responsible for Bills and Payment:

Relationship to patient: _____ Name: _____ DOB: _____

Mailing Address: _____ ZIP Code: _____City: _____ State: _____

Best Phone Number: _____

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COMMUNICATION PREFERENCES

Patient Name (last, first, middle): _____ Date of Birth:_____

Authorization to Disclose Information to Others:

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.).

I give permission to release the following information to the individuals listed below:

- ❏ All health information about me created or received by Orchid Health, including medical records, case or medical management, billing, payment, claims and enrollment, mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.
- ❏ All health information **except for**: mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

Name	Relationship	Phone Number

Personal Communication Methods:

As our patient, we may need to communicate with you outside of our clinic. To assure your privacy, we would like you to indicate whether it is OK or not to leave medical information (such as normal lab results) on a voicemail if we are unable to reach you.

Home Phone # _____:

___ Do NOT leave messages
___ May leave call back numbers only
___ May leave messages with details

Mobile Phone # _____:

___ Do NOT leave messages
___ May leave call back numbers only
___ May leave messages with details

TERM: This authorization will remain in effect for a period of **one year**. I can revoke this authorization in writing (at any time) as described in the Orchid Health Notice of Privacy Practices.

Signature _____ Date _____

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MEDICAL RECORDS RELEASE

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B. _____

_____ S.S.# _____

City, State, Zip

Best Contact Phone _____

I Authorize Information Released FROM: (please print)

Clinic/Doctor's Name: _____

Address: _____

City, State, Zip:_____

Please Send My Records TO: (fax preferred)

Orchid Health Wade Creek
535 NE 6th Ave.
Estacada, OR 97023
Fax: (503) 630-8551
Phone: (503) 630-8550

Orchid Health Oakridge
47815 Highway 58
Oakridge, OR 97463
Fax: (541) 782-5823
Phone: (541) 782-8304

Purpose of Release

❒ Establishing New PCP ❒ Sharing Health Information (from Consultant/Specialist) ❒ Personal Use ❒ Legal

Type of Information To Be Released- Initial **ALL** that apply

____**Complete** Medical Records ____ Include Mental Health Records ____Include Confidential Records/HIV or other

____ Include Records relating to Drug or Alcohol Treatment:_____

____Other (specify): _____

This authorization will expire one year from the date of the signature below.
I understand that I can change my mind about this authorization at any time by writing to the health care provider or to Orchid Health, but that any information already transferred will remain in our Confidential Medical Record System.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Orchid Health may redisclose the information if it is relevant for consultation, or if you request we transfer your records to another location.
- I am allowed to receive a copy of this Authorization.

Signature _____ Date _____

Relationship to Patient: _____

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Chronic Opioid and Controlled Substances Policy

For your protection, Orchid Health follows state and local prescribing guidelines for safely prescribing controlled substance medications (opiates, benzodiazepines and stimulants). **Please review and sign this form if you are currently taking any controlled substances.**

- Controlled substance medications will not be prescribed at your first clinic visit.
- Your previous medical records *must be received and reviewed* prior to the prescription of controlled substances.
- Medical records must be sent directly from your previous clinic to Orchid Health electronically or via fax (hand carried copies are not acceptable).
- If you currently take a daily opiate, benzodiazepine, or stimulant medication you can request a "bridge" prescription from your previous prescribing clinician until your assessment is complete.
- Orchid Health clinicians will not prescribe chronic opioid medications above 60 MED ("daily morphine equivalent dose") for non-cancer related pain. If you are on a chronic opiate dose higher than this you will need to taper down before establishing care with Orchid Health (your previous prescriber can help you with this taper).
- To determine if chronic opiate use for non-cancer pain is appropriate, your assessment at Orchid Health will include a review of previous records and may include the administration of questionnaires regarding functional level, depression, anxiety, addiction risk and sleep quality. This information will be used to determine if continuation of chronic opiates is medically appropriate. We may determine that chronic opioid prescribing is not appropriate.
- A non-narcotic prescription trial may be required prior to any opioid medication being prescribed.
- A Controlled Substance Agreement, which allows for random urine drug screening, must be signed before the prescription of controlled substances by Orchid Health providers.

I, _____, have read the above information and acknowledge understanding of the Orchid Health New Patient Controlled Substance Policy.

_____ _____

Patient Signature Date

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Comprehensive New Patient Health History – Adult

Name _____ **Date of Birth** ___/___/_____ **Gender** ___

Did anyone assist you with completing this form? Yes/No **If yes, who?**_____

Current Medical Concerns (what you would like to talk about today):

1. (most important) _____
2. _____
3. _____

Have you received the following IMMUNIZATIONS (SHOTS?) ? If yes, then please try to indicate the approximate year it was given:

Influenza No ☐ Yes ☐ Year _____
Hepatitis A No ☐ Yes ☐ Year _____
Hepatitis B No ☐ Yes ☐ Year _____
Polio No ☐ Yes ☐ Year _____
Other (please specify) No ☐ Yes ☐ Year _____

Tetanus/Diphtheria No ☐ Yes ☐ Yr _____
Shingles Vaccine No ☐ Yes ☐ Yr _____
MMR (Measles/Mumps/Rubella) No ☐ Yes ☐ Yr_____
Pneumonia Shot No ☐ Yes ☐ Yr _____

Please list any ALLERGIES you have to medications:

NAME OF MED Reaction

_____

_____

Please list any MEDICATIONS that you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:

NAME OF MED Dose Directions (How often you take it)

_____

_____

_____

Do you have DIFFICULTY performing any of these activities by YOURSELF?

Eating	No ☐	Yes ☐	Walking	No ☐	Yes ☐	Dressing	No ☐	Yes ☐
Bathing	No ☐	Yes ☐	Using Toilet	No ☐	Yes ☐	Housekeeping	No ☐	Yes ☐
Errands	No ☐	Yes ☐	Driving	No ☐	Yes ☐	Managing Money	No ☐	Yes ☐

Family Health History

Are you adopted? Yes / No (If NO, please complete section below) P=Paternal M=Maternal

	Father	Mother	Grandmother P/M	Grandfather P/M	Brother	Sister	Aunt P/M	Uncle P/M
ADHD								
Alzheimer's Disease								
Alcoholism/Substance Abuse								
Aneurysm								
Anxiety or Depression								
Arthritis								
Asthma								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Manic-Depression or Bipolar								
Migraines								
MI = Heart Attack								
Osteoporosis								
Seizures								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

Personal Health History

ADHD or ADD	No ☐	Yes ☐	Endometriosis	No ☐	Yes ☐
Alcoholism/Substance Abuse	No ☐	Yes ☐	Fibromyalgia	No ☐	Yes ☐
Allergies/Hay fever	No ☐	Yes ☐	Gout	No ☐	Yes ☐
Anemia	No ☐	Yes ☐	GYN Problems	No ☐	Yes ☐
Anesthesia Complications	No ☐	Yes ☐	HIV	No ☐	Yes ☐
Anxiety Disorder or Recurrent Anxiety	No ☐	Yes ☐	Heart Problems	No ☐	Yes ☐
Arthritis	No ☐	Yes ☐	Hepatitis C	No ☐	Yes ☐
Asthma	No ☐	Yes ☐	High Blood Pressure/Hypertension	No ☐	Yes ☐
Autism Spectrum Disorder	No ☐	Yes ☐	High Cholesterol	No ☐	Yes ☐
Bipolar or Schizophrenia	No ☐	Yes ☐	Kidney Stones	No ☐	Yes ☐
Birth Defects or Inherited Disease	No ☐	Yes ☐	Kidney or Bladder Problems	No ☐	Yes ☐
Blood Transfusion	No ☐	Yes ☐	Liver Disease	No ☐	Yes ☐
Cancer	No ☐	Yes ☐	Migraines	No ☐	Yes ☐
Chicken Pox	No ☐	Yes ☐	Muscle, Joint, or Bone Problems	No ☐	Yes ☐
Clotting Problems - Bleed too much or History of Blood Clots	No ☐	Yes ☐	Osteoporosis	No ☐	Yes ☐
Depression	No ☐	Yes ☐	Reflux/GERD	No ☐	Yes ☐
Developmental or Behavioral Disorders	No ☐	Yes ☐	Seizures/Epilepsy	No ☐	Yes ☐
Diabetes or Pre-Diabetes	No ☐	Yes ☐	Skin problems (Rashes/Changing Moles)	No ☐	Yes ☐
Diverticulitis/Diverticulosis	No ☐	Yes ☐	Stomach Ulcers or Swallowing Problems	No ☐	Yes ☐
Domestic Violence	No ☐	Yes ☐	Stroke or TIA	No ☐	Yes ☐
Ear Infections - Chronic	No ☐	Yes ☐	Thyroid Problems	No ☐	Yes ☐
Ear or Hearing Problems	No ☐	Yes ☐	Tuberculosis or Positive TB Test	No ☐	Yes ☐
Eating Disorder like Anorexia or Bulimia	No ☐	Yes ☐	Vision or Eye Problems	No ☐	Yes ☐
Eczema	No ☐	Yes ☐	Other: _____	No ☐	Yes ☐
Emphysema/COPD/Chronic Bronchitis	No ☐	Yes ☐			

Have you ever had surgery? No ☐ Yes ☐

If YES, please list your surgeries (include the year if possible):

_____

_____

Have you stayed overnight in the hospital for other problems? No ☐ Yes ☐

If YES, please list them (include the year if possible):

_____

_____

Have you ever had any other serious injuries or broken bones? No ☐ Yes ☐

If YES, please list them (include the year if possible):

_____

_____

Have you had any of these TESTS? If yes, then please indicate when:

Colonoscopy No ☐ Yes ☐ Year _____ Bone Density Test No ☐ Yes ☐ Year _____

Pap Smear No ☐ Yes ☐ Year _____ Mammogram No ☐ Yes ☐ Year _____

Heart Testing/Stress Test No ☐ Yes ☐ Year _____

Social Health History

Do you Smoke? Yes / No **Do you use any other forms of Tobacco?** Yes / No

Tobacco Years of Use: _____ How Many Packs/ Day _____

Do you use E-cigarettes_____

Relationship Status: Married / Divorced / Widow(er) / Single / Other Partner

What is your current living arrangement? House Apartment Care Home Other_____

Do you live: Alone With Spouse/Family With Others:_____

Do you feel safe at home? No ☐ Yes ☐

Is there somewhere else you feel unsafe? No ☐ Yes ☐ **Where?**_____

Do you have concerns about meeting basic needs (food/clothing/shelter?) No ☐ Yes ☐

Do you have to follow a special diet? Yes/No **If Yes, describe:**_____

Education: What is your highest level of education? (What grade did you finish in school, or what degree or trade school after High School?) _____

Current Employment Status: Working / Unemployed / Retired / Intentionally Unemployed

Type of Work: _____

Disability: Are you disabled? Yes / No _____

Incarceration: Have you ever been incarcerated? Yes / No _____

How many times in the past year have you had heavy alcohol consumption? (5+ drinks for men, 4+ for women in one day)?

Never 1 or more

How many times in the past year have you used an illegal drug OR used a prescription drug for non-medical reasons?

Never 1 or more

How do you think of your Overall Health? ❒ excellent ❒ good ❒ fair ❒ poor

Have you ever been diagnosed with Depression or Anxiety? No ☐ Yes ☐

During the past TWO WEEKS, have you often been bothered by of the following problems?

- Feeling down, depressed, irritable or hopeless? No ☐ Yes ☐
- Little interest or pleasure in doing things? No ☐ Yes ☐

WOMEN: Is there a chance you are pregnant? No ☐ Yes ☐

Have you been pregnant before? No ☐ Yes ☐ (How many times?) _____

When was your last menstrual period? _____

Are you planning on becoming pregnant?_____

Is there anything else we have missed that you feel we should know about your health?

_____

_____

_____

_____

Thank you!