Thurston Medical Clinic
147 S 52nd Place
Springfield Oregon 97478
Office: (541) 746-1166 Fax: (541) 393-1607

Thank you for allowing us to become partners in your Health Care!

Enclosed you will find paperwork we need you to complete and bring with you for your appointment. Please **arrive 20 minutes <u>prior</u> to your appointment time with your completed paperwork**. This will enable our staff to have you ready to see your physician on time.

- If your insurance is a managed care plan, a referral is required from your primary care physician in order to be seen by a specialist. With a managed care plan, please call to make sure the referral has been requested from your primary physician and received by the specialist.
- As a courtesy, our office will contact your insurance company to verify coverage and benefits. Please call us if you have questions about the amount you will need to be prepared to pay at your first appointment. Co-payments, Co-insurance and Deductible amounts are payable at the time of service. We accept cash, checks made payable to Thurston Medical Clinic, Visa, MasterCard and Discover.
- **Late Appointments:** The office may need to reschedule your appointment if you are late.

<u>PRIMARY CARE APPOINTMENTS:</u>

- If you are establishing care with **any Thurston Medical Practitioner** for primary care, we may ask that you have your records sent from your previous physicians at the time of your appointment.
- The Physicians need you to bring your medications, including all over the counter medication and vitamins, in their original bottles.
- If you are establishing care with **any Thurston Medical Practitioner** as your primary physician and your insurance plan is managed care (Regence Medicare Advantage, Providence Medicare Extra, Secure Horizons, Cigna, or Aetna, etc….) **<u>PLEASE</u>** call your insurance and have your PCP changed prior to your appointment.

Appointment Policy

Our office requires 24 hour notice if an appointment cannot be kept. If you are unable to make your scheduled appointment, please notify us as soon as possible. You can call our main office number between 8am and 5pm. If before 8am or after 5pm, please leave a message on our voice mail. All "No Show" appointments are tracked within the patient's medical record. There is a $45.00 fee attached to all "No Show" appointments subsequent to the first offense. With any additional "No Show" appointments following the second notice, our office will be unable to schedule any appointments in advance. Patients may call our office on the day he/she is available to attend an appointment to inquire if there is an opening that would work for them. Continued missed appointments will subject the patient's account for review of possible termination from the Practice.

If you have any questions, please feel free to call the office during regular business hours.
We look forward to meeting you soon.

Warmest regards,

The Office Staff
Thurston Medical Clinic

REGISTRATION FORM (Use Blue or Black Ink Only)

Thurston Medical Clinic
147 S 52nd Place
Springfield Or 97478

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ___ Email: _____

Date of Birth: _____/____/_____ Maiden Name: _____ Patient Social Security #:_____/_____/_____ Gender: M F

Address: _____ City/State/Zip: _____

Home #: _____ Work #: _____ Cell#: _____

Primary care physician: _____ Phone #: _____

Marital Status: □ Married □ Domestic Partner □ Single □ Widowed □ Divorced □ Child

Race: □ Caucasian/White □ Asian □ Black/African Amer. □ Pacific Islander □ American Indian/Alaskan Native . □ Hispanic

Ethnicity: □ Non-Hispanic/Latino □ Hispanic/Latino **Primary Language**: _____

EMPLOYMENT INFORMATION (SCHOOL, IF STUDENT)

Employer / School Name: _____ Occupation: _____

RESPONSIBLE PARTY INFORMATION

□ Check here if Responsible Party is same as above

Last Name: _____ First Name: _____ Social Security #:_____/_____/_____

Address: _____ City/State/Zip: _____

Home #: _____ Work #: _____ Cell#: _____

Date of Birth: (mo/d/yr) _____/____/_____ Relationship to Patient: _____

EMERGENCY CONTACT PERSON

Last Name: _____First Name: _____ Relationship to patient: _____

Home #: _____ Work #: _____ Cell#: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ **☐ AS OF THIS DATE I HAVE NO INSURANCE.**

ID#: _____ Group#: _____ Employer: _____

□ Check here if Subscriber is same as Patient Subscriber Name: _____

Subscriber DOB: (mo/d/yr) _____/_____/_____ Subscriber Relationship to Patient _____

Subscriber Address: _____ City/State/Zip: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

ID#: _____ Group#: _____ Employer: _____

□ Check here if Subscriber is same as Patient Subscriber Name: _____

Subscriber DOB: (mo/d/yr) _____/_____/_____ Subscriber Relationship to Patient _____

Subscriber Address: _____ City/State/Zip: _____

BUSINESS AND CREDIT POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

As a service to our patients, we bill primary and secondary insurance directly. Please understand that insurance coverage is an agreement between you and your insurance company. We will assist in resolving any problems that may arise for payment of your claims but do require you to be the lead advocate in the process.

If you are a new patient to our office; please note that our billing department will call to verify your insurance benefit package prior to your first appointment. We will notify you of the patient portion due at the time of your visit based on your individual policy. Co-payments are due at the time of each visit. Our office accepts both Visa, MasterCard and Discover for your convenience. We request that the balance be paid within 30 days of your receipt of our statement.

If a Primary Physician referral is required by your insurance policy to see a specialist in our practice, we ask that you ensure ALL (name of referring physician, insurance ID#, & name of employer) information has been provided, and assist in contacting your Primary Physician's office and initiate the process. If you do not have a referral in place and choose to still be seen by one of our physicians, it will require you to sign a waiver and pay at the time services are rendered.

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our business office. This will avoid misunderstandings and enable you to keep your account in good standing. Our business office phone number is 1-877-708-1119 .

A parent or legal guardian must accompany minor patients to all appointments.

I have read, understand, and agree to the above Business and Credit Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to the applicable physician that rendered medical services. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____ _____

Responsible / Insured person, Parent or Guardian Date

If Patient is a Minor:

PERMISSION TO TREAT IF NOT IN THE PRESENCE OF PARENT OR GUARDIAN
Any Practitioner of Thurston Medical Clinic

May unconditionally treat: _____ _____/_____/_____
Patient Name Birthdate

in my presence or absence without reservation.

_____ _____ _____

Signature Relationship Date

Thurston Medical Clinic
147 S 52nd Place Springfield Or 97478 Phone: (541) 746-1166

AUTHORIZATION TO DISCUSS HEALTH INFORMATION (verbal communication only)

Patient Name: **Patient DOB:**

Identification password: _____ (the authorized person below will need to know this password)
Optional

I authorize Thurston Medical Clinic to discuss the areas I have identified below with the individual listed (Friends and Family members). I acknowledge with the signing of this form the medical data to be released may include information that is specific to HIV/AIDs, drug and or alcohol and / or psychiatric treatment if I have initialed those items separately.

If you choose to restrict disclosure to someone you previously authorized, please ask for our "Restriction form".

PLEASE PRINT (use black ink)

_____ _____
Name and phone # of person authorized (One person per line) **Relationship to you**

☐ Unlimited access (to all information listed below)
- ☐ Financial information
- ☐ Discuss Treatment
- ☐ Appointment scheduling/cancellation
- ☐ Sexually transmitted diseases

MUST BE INITIALED TO BE INCLUDED:

_____**Alcohol/Drug Treatment**
_____**Psychiatric Information**
_____**HIV/AIDS information**
_____**Genetic information**

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosure already made with your permission. To revoke this Authorization, please send a written statement to attention of Privacy Officer, 147 S 52nd Place Springfield, OR 97478. The notice should include the full name and relationship of the person you are revoking privileges from, along with your full name, date of birth, current date and signature.

The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law.

_____ _____
Signature *Date*

This authorization will remain in effect unless a stop date is identified or a written notice to revoke is received.

Stop Date:

NOTE-THIS IS NOT A RECORDS RELEASE FORM

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information;

Please complete the following which tells us how you wish to be contacted.

I, _____ wish to be contacted in the following manner (check all that apply):
*(If you choose to be contacted by phone it is **REQUIRED** that you customize your message to include your phone number or full name so that we are able to verify that we have reached the correct number)*

Home Telephone Number _____

□ Leave detailed message **WITH** medical/financial information on voice mail

Work Telephone Number _____

□ **Only** leave message with department/office name and call-back number on voicemail
OR
□ Leave detailed message **WITH** medical/financial information on voicemail

Cell Telephone Number _____

□ Leave detailed message **WITH** medical/financial information on voice mail

In which order should we call the above phone numbers (listed above?

Call First:	Home	Work	Cell (circle one)
Call Second:	Home	Work	Cell (circle one)
Call Last:	Home	Work	Cell (circle one)

Our office will continue to communicate with you according to your above response (s) until you change your preferences. You may do so by completing a new form at any time.

By your signature below, you agree to be communicated in the above manner and recognize that Thurston Medical Clinic has no control over who has access to your message machine.

Patient Signature _____Date _____

Thurston Medical Clinic

Acknowledgment
Privacy Policy Offered

09/20/16

This is an acknowledgement that you have been offered a copy of the Thurston Medical Clinic Privacy Policy, which includes but is not limited to information about the Practices use and disclosure of your Health Information.

- ***Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).*
- ***Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and preauthorization).*

***Health Care Operations** (includes the necessary administrative and business functions of our office).*

We reserved the right to change our privacy practices in accordance with the law. The terms contained in the ***Policy*** may change also. A summary of the ***Policy*** will be available in the lobby of our office indicating the revised effective date in the bottom right hand corner. A copy of the ***Policy*** will be included in each new patient packet. We will offer each existing patient an initial copy of the ***Policy*** & will provide an additional copy upon request.

I understand that it is my responsibility to read the policy I have been offered and if I have any questions or need clarification I can contact the Privacy Officer Teresa Allen @ 541-746-1166.

_____
(Print Patient Name)

_____ _____ or
(Date) (Signature of patient)

_____ _____
(Date) (Signature of legal guardian if patient is a minor)

If Patient is a Minor, over the age of 14:

_____ _____
(Date) (Signature of patient)

THURSTON MEDICAL CLINIC
NOTICE OF PRIVACY PRACTICES
Effective Date: September 1, 2016

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.

If you have any questions about this notice, please contact Teresa Allen designated privacy official at 541.746.1166

147 S 52nd Place, Springfield Or 97478

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from your Provider. Your health information may include information created and received by your provider, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our organization may share information about you and disclose information to people who do not work for Thurston Medical Clinic in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

For payment. We may use and disclose health information about you so that the treatment and services you receive at Thurston Medical Clinic. may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run Thurston Medical Clinic and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.
In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Teresa Allen, *designated privacy official* in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our *privacy official Teresa Allen*.
  You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by your provider.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to Teresa Allen our *designated privacy official*.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request

the rebuttal be made a part of your medical record. Your rebuttal needs to be 3 of pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to Teresa Allen at 147 S 52nd Place Springfield, OR 97478, phone 541-746-1166.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Teresa Allen. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. [*You may also find a copy of this Notice on our web site.]*

  To obtain such a copy, contact Teresa Allen at 541-746-1166

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. {*If a direct care provider* - We will post the current notice at our location(s) with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region
U.S. Department of Health & Human Services

To file a complaint with Thurston Medical Clinic, contact Teresa Allen at 147 S. 52nd Place Springfield, OR 97478, 541-746-1166. ***You will not be penalized for filing a complaint.***

Thurston Medical Clinic– Medical Summary Date:

Patient Name:	Preferred Name:	DOB:	Pt ID#:

Please List Your Primary Health Concerns:

Medical Problem List:

Medication Reconciliation (Please **bring all** your medications/supplements when you come in)

Name:	Strength:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Medication Allergies:

_____

Pharmacies that you use:

Mark Immunizations you have had (For recommended immunizations www.cdc.gov/vaccines/schedules)					
☐ Influenza	Date:	☐ Hepatitis B	Date:	☐ Hepatitis A	Date:
☐ Varicella	Date:	☐ Meningococcal	Date:	☐ Gardasil (HPV)	Date:
☐ Shingles (Zostavax)	Date:	☐ Pnevmovax (23)(old Pneumonia shot)	Date:		
☐ Measles, Mumps, Rubella (MMR)	Date:	☐ Prevnar (New Pneumonia Shot)	Date:		
☐ Tetanus, Diphtheria, Pertussis, TDAP	Date:	☐ Have you ever had Chicken pox or exposure to	Date:		

Health Maintenance – Exams you have had done:		
Eye Exam	Date:	☐ Never
Pelvic Exam or Pap Smear (Female only)	Date:	☐ Never
Mammogram (Female only)	Date:	☐ Never

Patient Name: DOB:

History of HIV Testing	Date:	☐ Never
Colonoscopy	Date:	☐ Never
Stool Testing	Date:	☐ Never
Bone Density	Date:	☐ Never
A1C (Patients with Diabetes)	Date:	☐ Never
PSA (Males only)	Date:	☐ Never
XRays (by other Providers)	Date:	☐ Never
Labs (by other Providers)	Date:	☐ Never
INR/Prothrombin/Coumadin/Afib/blood thinners (*if applicable what is current dose)	Date:	☐ Never

Have you had any hospitalizations, operations, or health events (existing patients since last exam)?

Do you drink caffeine? ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no If yes, how many per day?:

MEN: How many times in the past year have you had 5 or more drinks in a day?	☐ None	☐ 1 or more
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	☐ None	☐ 1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	☐ None	☐ 1 or more

What recreational drugs have you used?

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "x" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Healthcare professional , add Columns:				
For interpretation of TOTAL, please refer to accompanying scoring card.	TOTALS			

Patient Name: DOB:

Tobacco Use	Ever used ☐YES ☐NO	When:	What type:	Date stopped:
	Current use:	What type:		How much:

What measures have you used to stop?
See (www.smokefreeoregon.com)

Social History:

Marital Status: ☐ Single ☐ Single w/Partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Occupation:

Sexual History

Sexually Active ☐ YES ☐ NO Monogamous Relationship ☐ YES ☐ NO

Have you ever had a sexually transmitted disease? ☐ YES ☐ NO Are you worried about having a STD? ☐ YES ☐ NO

Women's Health

Are you having menses? ☐ YES ☐ NO Are menses monthly? ☐ YES ☐ NO Last menstrual period Date:

Painful ☐ YES ☐ NO Any Problems?	Post Menopausal ☐ YES ☐ NO History of Hormone Replacement Therapy ☐ YES ☐ NO

# of Pregnancies: # of children: Birth Control Method:

Prior hysterectomy: Ovaries Removed?:

Patient Assistive Devices

Eyeglasses: ☐ Reading ☐ Distance ☐ Driving	☐ Hearing Aids	☐ Cane	
☐ Walker	☐ Wheelchair	☐ Home Oxygen	☐ Incontinence Pads
☐ CPAP	☐ Other:		

Do you have trouble with: ☐ Hearing ☐ Eyesight ☐ Memory ☐ Ambulation ☐ Balance ☐ Incontinence

Have you had any Falls recently?

Family History

Relation	Age	Medical Illnesses	Age at Death	Cause of Death	Any Family history of :
Father					☐ Diabetes ☐ Hypertension ☐ Coronary Disease ☐ Cancer ☐ Stroke ☐ Other Diseases:
Mother					
Brother/Sister					
Brother/Sister					
Brother/Sister					
Brother/Sister					
Spouse					
Child					
Child					
Child					
Child					

Patient Name: DOB:

Diet and Weight

Are you on a special diet? ☐ YES ☐ NO Do you have dietary concerns? ☐ YES ☐ NO

Has your weight changed? ☐ YES ☐ NO Do you exercise 3 or more times a week? ☐ YES ☐ NO

General Health

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How much pain have you had during past 4 weeks? ☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Activities of Daily Living

Following tasks are you:	Independent: can do by myself	Require Assistance: need help from another	Dependent: cannot do at all		Independent: can do by myself	Require Assistance: need help from another	Dependent: cannot do at all
Walking	☐	☐	☐	Using Telephone	☐	☐	☐
Dressing	☐	☐	☐	Shopping	☐	☐	☐
Bathing	☐	☐	☐	Preparing Meals	☐	☐	☐
Eating	☐	☐	☐	Housework	☐	☐	☐
Toileting	☐	☐	☐	Taking Medication	☐	☐	☐
Driving	☐	☐	☐	Managing Finance	☐	☐	☐

End of Life Planning:

Do you have an advanced directive or living will? ☐ YES ☐ NO

If not, are you interested in discussing at your next appointment? ☐ YES ☐ NO

Other Medical Providers. These are the current specialists co-involved in my care:

Specialty/Reason Name	**If new Patient list any medical problems:**
Ophthalmologist	
Cardiologist	
Pulmonologist	
Gastroenterologist	
Oncologist	
Dermatologist	
Orthopedist	
Urologist	
Gynecologist	
Allergist	
Dental	
Therapist	
Psychologist/Psychiatrist	
Other	

Have you recently traveled outside of the U.S.? ☐ Yes ☐ No Do you plan on traveling outside of the U.S.? ☐ Yes ☐ No