



868 E Riverside Dr., Ste 170  
Eagle, ID 83616

P: 208.514.0670

F: 208.549.7880

Keystone.Health

## Welcome to Keystone Health - Medical Housecall.

We are honored that you have chosen us to be your Primary Care Provider. We understand how disorienting and cumbersome the process of going to the doctor can be for seniors and people with difficulty getting out of their home. That's why our providers come to you. Our providers are highly trained professionals committed to treating you or your loved one with compassion, respect, and dignity.

The following pages are our new patient paperwork. Please carefully fill them out, and send or fax them to our office. Once we have received the forms, we will contact you to schedule our first visit. Please have your insurance card available on your first visit, as well as your medication bottles or a detailed list of medications and doses available for your provider to review.

Should you need to cancel or reschedule your visit, please provide 1 business day notice.

Thank you for taking the time to fully complete these forms. The rest of this book is for you to keep. If you have any questions about Medical Housecall services provided by Keystone Health or scheduling your first visit, please visit our website or contact us at **208-514-0670**.

We look forward to working with you.

Sincerely,

The Keystone Health - Medical Housecall Team

### Checklist:

- New Patient Information
- Office Policies
- Completed Release Form
- General Consent to Treatment
- Assignment of Benefits
- Notice of Privacy Practices Acknowledgement
- Residence and Living/Emergency Contact
- Advance Directives/DNR/DNI
- Health History



The care you need.  
The support you deserve.

# CCM INFORMED CONSENT FORM

## Dear Patient,

You are eligible for a new Medicare program that enables us to provide you with around-the-clock service to oversee your chronic conditions and improve your overall wellness. Chronic conditions are ongoing medical problems like diabetes, high blood pressure, dementia, heart disease, depression, osteoporosis, and many others. These conditions must be managed effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness.

What are the benefits of signing up for Chronic Care Management Services?

- Coordinate visits with your doctors, facilities, labs, radiology, or others
- Provide access to around-the-clock (24/7) services from your care team
- Assist with management of medications
- Provide a personalized and comprehensive care plan management
- Assist with scheduling preventive care services, many of which are covered by Medicare

**NOTE:** You must sign an agreement to receive this type of chronic care management services.

## What do you need to know before signing up?

Medicare will allow us to bill approximately \$42 for these services during any month that we have provided at least 20 minutes of non-face-to-face chronic care management services.

Medicare will reimburse us approximately \$32 and requires you to pay approximately \$8 to \$9 (your Medicare co-insurance amount, may be covered by your secondary insurance) each month that you receive at least 20 minutes of chronic care management. Our office will have the record of when and how the 20 minutes were spent and you will have 24/7 access to your electronic medical record if you ever have questions.

Our practice is compliant with HIPAA and all laws related to the privacy and security of Protected Health Information (PHI). As a part of this program, your PHI may be shared between care givers directly involved with your health.

## You have a right to:

Discontinue this service at any time for any reason.

Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form. The provider will continue providing CCM services until the end of the month and may bill Medicare for those services. After the end of the month, the provider will discontinue CCM services and no longer bill for those services to Medicare.

**NOTE:** Only one physician can bill for this service for you. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

The goal of Keystone Health is to make sure you get the best care possible from everyone that is involved with your health.

I agree to participate in the Chronic Care Management program.  Yes  No

Print Name \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature \_\_\_\_\_

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## Keystone Health - Medical Housecall – New Patient Info

Welcome to the Keystone Health. Please print clearly and answer all questions as completely as possible.

### Patient Information

Full Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Legal Last Name) (Legal First Name) (Middle Initial) (Preferred First Name)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex/Gender: \_\_\_\_\_

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Street/PO Box) (City) (State) (Zip Code)

Phone #: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
(Home) (Work) (Cell/Other)

Occupation/Employer: \_\_\_\_\_  Full-Time  Part-Time  Student  Retired  Unemployed

Are you:  Single  Married  Partnered  Divorced  Widowed Partner's Name: \_\_\_\_\_

### Additional Information (Please fill out all fields below)

E-mail Address: \_\_\_\_\_

Can we leave a message regarding your medical care and test results?  Yes  No

Race (please select):  White  American Indian or Alaska Native  Asian  Hispanic  
 Native Hawaiian or Pacific Islander  Black or African American  Other  Decline

Preferred Language (please select one):  English  Bosnian  Indian (including Hindi & Tamil)  Russian  
 Sign Language  Spanish  Other

Preferred Pharmacy Location: \_\_\_\_\_

### Please provide your emergency contact information below

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Street/PO Box) (City) (State) (Zip Code)



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### Responsible Party Information

Full Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Legal Last Name) (Legal First Name) (Middle Initial) (Preferred First Name)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex/Gender: \_\_\_\_\_

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Street/PO Box) (City) (State) (Zip Code)

Phone #: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
(Home) (Work) (Cell/Other)

Occupation/Employer: \_\_\_\_\_  Full-Time  Part-Time  Student  Retired  Unemployed

Are you:  Single  Married  Partnered  Divorced  Widowed Partner's Name: \_\_\_\_\_

### Primary Insurance

Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

ID/Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary on Policy?  Yes  No, answer following for Primary Insured:

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's ID #: \_\_\_\_\_ Patient's Relationship to Insured: \_\_\_\_\_

### Secondary Insurance<sup>1</sup>

Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

ID/Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary on Policy?  Yes  No, answer following for Primary Insured:

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's ID #: \_\_\_\_\_ Patient's Relationship to Insured: \_\_\_\_\_

By signing below, I verify that the above information is correct and true to the best of my knowledge. I authorize Keystone Health to treat me. I authorize all insurance payments to be made directly to Keystone Health. I consent to the release of all information the insurance company may request for filing their claims. I understand Keystone Health will bill my insurance as a courtesy to me, but many insurance companies do not cover all charges, and that I will be responsible for and will pay for any charges not covered by my health care plan. I have received and reviewed the handout called *Privacy Practices Notice*. I understand that I can ask for further information if needed.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Office Policies

**Please take the time to read, initial, and sign our Office Policies to acknowledge your understanding of them. We have found this policy to be most effective for both patients and providers. Outstanding balances can cause embarrassment and communication breakdowns, and potentially decrease adherence to the prescribed treatment program. If you have any questions regarding these agreements, please discuss them with Keystone Health staff.**

Your insurance policy is a contract between you and your insurance company. Keystone Health is not a party to that contract. As a service to you and upon your request we can bill your insurance provider. It is your responsibility to provide our office with your insurance details and present your insurance card to our staff so we can bill your insurance carrier completely and accurately. When possible, our staff will call to verify your insurance coverage prior to your appointment. Please be aware that an estimate of benefits is not a guarantee of payment. If an insurance company provides you or our staff with inaccurate information they may not honor the benefits that were quoted.

**Please initial here \_\_\_\_\_**

It is your responsibility to be aware of your coverage and co-pay, as well as any deductible and maximums, per your insurance contract. All co-payments, co-insurance payments, deductibles, supplements/products, supplies, therapeutic equipment, and costs of services not covered by your insurance company are due and payable at the time of each visit.

**Please initial here \_\_\_\_\_**

PLEASE NOTE: There is a \$50.00 fee for each no-show and/or appointment cancellation with less than 24 hours notice. When you schedule an appointment we reserve that time, carefully planned within the context of the week's schedule, exclusively for you. If you miss that appointment or cancel with less than 24 hours notice, it is too late to schedule another patient for your reserved appointment time. This results in a loss of income to both your practitioner and the clinic. In addition, we also incur administrative expenses related to scheduling, with less than 24 hours notice, regardless of the reason for the missed appointment, please be sure to notify us at least 24 hours in advance to avoid being charged.

**Please initial here \_\_\_\_\_**

Once we receive payment from your insurance company, we will apply this to your bill. If we find you have a credit, this will remain on your account for use toward future services and/or purchases. If instead you would like to be issued a refund, please let us know and we will be happy to issue you a check.

**Please initial here \_\_\_\_\_**

Patients must be responsible for following the referral, prescription, or treatment plan prescribed by their physician, practitioner, and/or insurance provider. Insurance companies may not pay for services when the treatment plan is not followed, thus patients are responsible for scheduling and attending appointments accordingly.

**Please initial here \_\_\_\_\_**

Patients are responsible for notifying Keystone Health if their insurance coverage or details change.

**Please initial here \_\_\_\_\_**

As a patient of Keystone Health, I acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Relationship to Patient (if not self)

\_\_\_\_\_  
Patient Signature (or Responsible Party)

\_\_\_\_\_  
Date



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## Release to Obtain Medical Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ SSN #: \_\_\_\_\_

I request and authorize:

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

to release healthcare information of the patient named above to:

Name: KEYSTONE HEALTH - MEDICAL HOUSECALL  
 Address: 868 E RIVERSIDE DRIVE, STE 170  
 City: EAGLE State: ID Zip Code: 83616  
 Phone: 208.514.0670 Fax: 208.549.7880

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

All healthcare information

Other: \_\_\_\_\_

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

\_\_\_\_\_  
 Patient Name (Please Print)

\_\_\_\_\_  
 Relationship to Patient (if not self)

\_\_\_\_\_  
 Patient Signature (or Responsible Party)

\_\_\_\_\_  
 Date

THIS AUTHORIZATION IS IN EFFECT FOR THE DURATION OF YOUR TREATMENT.



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## General Consent to Treatment

I hereby voluntarily consent to the performance of such diagnostic procedures and/or medical treatment as my physician, non-physician practitioner (PA-C/CNP), their assistants or designees at Key Stone Health may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, specialty referrals, and routine medical care. I authorize my physician(s) or provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my physician/provider and that other personnel render care and services to me according to the physician's instructions.

- I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with regard to results of such diagnostic procedures or medical treatment.
- I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostic procedures, and authorize Key Stone Health to properly dispose of these body fluids.
- I have been informed and understand that an HIV (Human Immunodeficiency Virus- AIDS) test may be performed on me without my consent if a health professional or Key Stone Health employee sustains an exposure to my blood or other body fluid.

**I acknowledge that I have read or have had read to me this consent, and fully understand its details. I have had the opportunity to ask questions, and have had these questions addressed.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**If patient is unable to sign:**

Consent of Legal Guardian, Power of Attorney for Health Care, or Patient Advocate

Consent of Caregiver or Nearest Relative

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

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

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



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## Assignment of Benefits

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Other/Secondary Insurance: \_\_\_\_\_ Policy Number: Group Number: \_\_\_\_\_

I hereby assign and request that payment of authorized insurance benefits, including Medicare if applicable, be made on my behalf to Key Stone Health for any medical services provided.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Key Stone Health, the Centers for Medicare and Medicaid Services, any other insurance carrier with whom I have coverage.

I understand that I am financially responsible to Key Stone Health for any charges not covered by health care benefits, and I am only responsible for any deductible, co-pay or other amounts for services not covered by my insurance. I understand that Key Stone Health agrees to accept the payment made by Medicare and any other insurance coverage as its full charge. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. It is my responsibility to notify Key Stone Health of any changes in my health care coverage. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

**I acknowledge that I have read or have had read to me this assignment of benefits, and fully understand its details. I have had the opportunity to ask questions, and have had these questions addressed.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If patient is unable to sign:**

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

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

**Please attach copy of insurance cards**





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## Notice of Privacy Practices Acknowledgement

I was offered a copy of Keystone Health's Privacy Practices

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

[OR]

### If patient is unable to sign:

Received by Legal Guardian, Power of Attorney for Health Care, or Patient Advocate

Received by Caregiver or Nearest Relative

Name (Print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

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

### FOR ADMINISTRATIVE USE ONLY:

**Keystone Health** has made a good faith effort to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices and Individual Patient Rights.

#### Acknowledgement could **not** be obtained for the following reason(s):

Patient/Individual refused to sign (*Date of refusal: \_\_\_\_/\_\_\_\_/\_\_\_\_* )

Communication barriers prohibited obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other: \_\_\_\_\_

Attempt made by: \_\_\_\_\_ Date attempt made: \_\_\_\_/\_\_\_\_/\_\_\_\_



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## Residence and Living

### Primary Caregiver or Facility

(Person responsible for providing day-to-day care for the patient. Appropriate documentation must be provided.)

- N/A - I do not have a primary caregiver  Same as emergency contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Legal Guardian or Healthcare Proxy

(Court appointed person to make healthcare decisions in place of patient. Appropriate documentation must be provided.)

- N/A - I do not have a Legal Guardian or Healthcare Proxy  Same as emergency contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Emergency Contact

**Please provide your emergency contact information below.**

Name (Print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

## Consent to Contact

### Consent for communication with delegated individual

By initialing, I authorize Keystone Health to communicate with the following individual about my health care which may include information about my medical diagnosis, eligibility status and appointments.

_____	_____	_____	_____
First Name	Last Name	Relationship	Initials

## Terms of Consent

By signing below, I agree to the terms and information above. I am giving this consent of my own free will. I fully release Keystone Health as well as their Officers, Directors, Board Members, employees, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several) payments, obligations, penalties, claims, litigation, demands, defenses, judgements, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorney, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services.

I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

_____	_____
Client Name Printed	Initials

_____	_____
Signature of Client or Parent/Guardian or Power of Attorney	Date

_____	_____
Witness Signature	Date



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## Advance Directives/DNR/DNI

### Living Wills and Idaho’s Natural Death Act

We plan for many important events in life. We plan for retirement, a wedding, vacations, and for a child’s education. Sadly, the health choices that are made at the end of life are seldom planned and many times they are made for us. Decisions are put off and desires are not expressed because it is difficult to contemplate or discuss death.

There are many things to plan for at the end of life. Transfer of property and the well being of a spouse or child are all issues to be considered and planned for. However, the topic discussed here involves end of life health care issues, the importance of living wills, and advance directives. The principle way to ensure that your desires are fulfilled if you are no longer able to communicate your wishes is through a Living Will.

Idaho law provides for individuals to ensure that their wishes about their healthcare are carried out in the event they become incapacitated and are not able to speak for themselves. Generally, there are two kinds of Advance Directives. The first is called a Living Will, and the second is called a Durable Power of Attorney for Health Care. During the 2005 Idaho Legislative session, a modification was made to the Natural Death and Medical Consent Act. Consequently, in Idaho, it is now possible to complete one (1) form for both a Living Will and a Durable Power of Attorney for Healthcare.

A Living Will sets forth your instructions for dealing with life-sustaining medical procedures in the event you are unable to decide for yourself. A Living Will directs your family and medical staff on whether to continue, withhold, or withdraw life-sustaining medical procedures, such as tube feeding for hydration (water) and nutrition (food), if you are incapable of expressing this yourself due to an incurable and terminal condition or persistent vegetative state.

A Durable Power of Attorney for Health Care allows you to appoint a person to make all decisions regarding your health care, including choices regarding health care providers and medical treatment, if you are not able to make them yourself for any reason.

You should not execute and Advanced Directive without having first thought about end of life issues, considered your personal values, and discussed your end of life wishes with your family, physicians, attorney, and clergy.

### Advance Directives

I am informed of my rights to formulate an Advance Directive. I am aware that I am not required to have an Advance Directive in order to receive medical treatment by any healthcare provider. The terms of any Advance Directive that I execute will be followed by any healthcare provider and my caregiver to the extent permitted by the law.

<b>DO YOU HAVE ANY ADVANCE DIRECTIVES?</b>				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Do Not Resuscitate	<input type="checkbox"/> Medical Power of Attorney	<input type="checkbox"/> Living Will

If the answer is No, would you like information on Advance Directives, POST/DNR and the Idaho Registry?  Yes  No

By signing below, I verify that the above information is correct and true to the best of my knowledge. I authorize Keystone Health to treat me. I authorize all insurance payments to be made directly to Keystone Health. I consent to the release of all information the insurance company may request for filing their claims. I understand Keystone Health will bill my insurance as a courtesy to me, but many insurance companies do not cover all charges, and that I will be responsible for and will pay for any charges not covered by my health care plan. I have received and reviewed the handout called *Privacy Practices Notice*. I understand that I can ask for further information if needed.

\_\_\_\_\_  
 Patient or Responsible Party Signature

\_\_\_\_\_  
 Date



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## Health History

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Name Today's Date Date of Birth Age

Please line through any questions that do not apply to you

**Current Medications** (include prescription and non-prescription drugs, birth control pills, herbs, supplements)

\_\_\_\_\_

\_\_\_\_\_

**Allergies and Reactions** (medication and foods)

\_\_\_\_\_

\_\_\_\_\_

**Are you currently under the care of a doctor?** (list name and type of doctor)

\_\_\_\_\_

**Preventive Care** (Write the name of your most recent)

_____ Tetanus booster vaccine	_____ Flu Vaccine	_____ Eye Exam
_____ Hepatitis A vaccine	_____ TB skin test	_____ Dental Exam
_____ Hepatitis B vaccine	_____ HIV test	
_____ Pneumonia vaccine	_____ Syphilis-RPR test	

**Family History** (Include Mother [M], Father [F], Brother [B], Sister [S], Grandmother [GM], Grandfather [GF])

_____ Cancer	_____ Heart attack before age 50	_____ Osteoporosis
_____ Diabetes (insulin/diet control)	_____ High blood pressure	_____ Mental Illness
_____ Genetic problem/birth defect	_____ High cholesterol	_____ Other: _____

**Personal Medical History** (Check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chest pain, difficulty breathing  | <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Frequent or severe headaches       |
| <input type="checkbox"/> Birth Defects   | <input type="checkbox"/> Numbness of arms or legs              | <input type="checkbox"/> Abdominal/pelvic pain or infection |
| <input type="checkbox"/> Redness, pain in legs   | <input type="checkbox"/> Unusual vaginal bleeding or discharge | <input type="checkbox"/> Stomach/bowel problems             |
| <input type="checkbox"/> Uterine fibroid or tumor  | <input type="checkbox"/> Kidney or bladder disease             | <input type="checkbox"/> Breast discharge/lump              |
| <input type="checkbox"/> Sickle cell trait disease   | <input type="checkbox"/> Discharge from penis                  | <input type="checkbox"/> Blood transfusions                 |
| <input type="checkbox"/> Hepatitis A, B, C   | <input type="checkbox"/> Anemia                                | <input type="checkbox"/> Liver problems                     |
| <input type="checkbox"/> High cholesterol  | <input type="checkbox"/> HIV                                   | <input type="checkbox"/> High blood pressure                |
| <input type="checkbox"/> Herpes, warts syphilis, chlamydia, and/or gonorrhea   |  | <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> Do you think you are currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |  | <input type="checkbox"/> Hear murmur/problem                |
| # of pregnancies: _____ # of live births: _____  |  | <input type="checkbox"/> Blurred or double vision           |
| Date of last menstrual period: _____ <input type="checkbox"/> N/A-Menopausal   |  |   |



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**Personal Medical History, Continued** (Check all that apply)

- Swollen legs/ankles
  - Increase in thirst or urination
  - Stomach/bowel problems
  - Skin allergies/irritation
  - Seizure disorder
- Surgical history: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- Emotional problems/depression: (list) \_\_\_\_\_  
 \_\_\_\_\_

**Patient Mental Health Assessment**

In the last 14 days have you experienced any of the following:

- Depressed/anxious mood, sadness/crying most of the day, nearly every day?  Yes  No
- Less interest or pleasure in all, or almost all activities, most of the day, nearly every day?  Yes  No
- A change in sleep patterns?  Yes  No
- Thoughts/attempts of hurting or killing myself or others?  Yes  No
- Have you heard or seen things that other people don't hear or see?  Yes  No

**Drug and Alcohol Use and History**

- Do you currently use tobacco?  Yes  No  
 How many per day? \_\_\_\_\_ For how long? \_\_\_\_\_
- Have you previously used tobacco?  Yes  No  
 How many per day? \_\_\_\_\_ For how long? \_\_\_\_\_ When did you quit? \_\_\_\_\_
- Do you currently drink alcohol?  Yes  No  
 How many per week? \_\_\_\_\_
- Do you currently use drugs?  Yes  No  
 Types and how often: \_\_\_\_\_
- Have you used drugs in the past?  Yes  No  
 Types, dates and how often: \_\_\_\_\_

I have answered all of the questions about my medical history and my present physical condition fully and truthfully. I have told the doctors or other designated health center personnel about any conditions I may have, which may affect my overall health care. It is my responsibility to inform my provider should this information change in the future. By signing below, I confirm that I have reviewed and answered the entire four page document. Any spaces left blank are not applicable to me.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Reviewing Provider's Signature\* Date

\* By signing above, I confirm that I have reviewed the entire two page document and obtained clarification from the patient as necessary. Any blank spaces in this history form should be lined through by the patient and initialed by the reviewing provider to identify that it is not applicable to the patient.