Dear New Patient:

We would like to welcome you to our practice. Our goal is to make your experience with us as pleasant as possible. In order to help us meet this goal we have listed some helpful hints to benefit you as well as help our practice operate efficiently.

Office Hours

Our office hours are Monday through Thursday 8:00 am to 5:00 pm, and Friday 8:00 am to 12:00 pm. Our office is closed on all major Holidays.

Medications

Please bring ALL medications and supplements in the bottle or a current medication list with you to all office appointments.

New Patient Registration

New patients must arrive 20 mins early to register unless otherwise instructed. Please bring photo ID and insurance cards. We also have an electronic intake screen (eIntake) to obtain a summary your health history packet that we ask you to complete within 72 hours of scheduling your appointment. Our practitioner will review this information prior to your appointment. Completing the eIntake and submitting it with copies of your insurance cards electronically will save you time in the office and make your waiting time as short as possible.

Billing and Insurance

If your insurance plan has a co-pay please be prepared to pay at the time of service each visit. We ask that you always make our staff aware of changes in address, phone numbers, and insurance as you sign in.

Phone Calls

We want to be responsive to your needs. If you need to speak with a healthcare practitioner or their assistant please call during office hours unless you have an urgent concern, then you can reach our healthcare practitioner on call after hours by calling the office and selecting option "9" from the menu.

Prescription Refills

Please ask your healthcare practitioner or nurse for all of your prescription refills at the time of your visit. This will ensure you have all of your needed medications. If you are needing a refill before your scheduled visit we ask that you contact the pharmacy and ask them to fax us a refill request to 423-661-6602. Any refill requests will be handled within 72 hours (3 business days) of our staff receiving the request.

Lab Results and Test Results

If you have lab work or test results pending, it is not necessary to call our office unless you have been instructed to do so by your healthcare practitioner. Our healthcare practitioner will discuss with you with the results during your scheduled face-to-face visit with the practitioner.

If you have any questions about any part of the registration process, or anything pertaining to your appointment, please feel free to call us. We are here to serve you.

Sincerely,

Scenic City Family Practice

Continued on next page / other side

You are scheduled for a 45-60 minute initial visit with our practice. This visit is intended to be an introduction to your new primary care practitioner and our practice. You will discuss your health history, bring your new healthcare practitioner up to date on your current health status and any concerns you may have. Typically this visit is not considered a wellness or a physical exam but instead will likely be billed as a new patient to establish care. Your insurance company will consider this a diagnostic office visit. It is your responsibility to find out how your insurance company will pay/cover this type of visit. If you have any further questions about your new patient visit please contact the office at 423-661-3600.

Please sign and date this form in acknowledgement of the above information:

_____	_____	_____
Print Name	Patient Signature/Guardian	Date

Continued on next page / other side

1. Appointment Confirmation Policy

At Scenic City Family Practice, we are committed to delivering quality, urgent and comprehensive health care. We greatly value our scheduled patients as they allow us to provide quality care in a timely manner.

When you schedule an appointment, we reserve that time just for you with our clinical staff and doctor. We are committed to honoring the appointment time of our scheduled patients, so it is critical that you **confirm your appointment within 24 hours of your appointment time and that you arrive no later than 10 minutes of the scheduled time**.

Our Responsibility to You:

- We promise to work with you to find the time that works best for you.
- We will call you in advance to remind you of your appointment and to ensure we are prepared to make your experience as pleasant as possible.

Your Responsibility to Us:

Appointments MUST BE CONFIRMED within 24 hours of the appointment time by responding to either a confirmation call, text, or email.

- If you miss our confirmation call or need a different appointment time, please contact us as soon as possible to either confirm or reschedule based upon current availability. You may respond to a text or email to confirm your appointment if the option is available, but you **MUST** respond to confirm by 5:00 PM EST the day prior to your appointment.
- Arrive on time or early for your appointment. **We will not hold your reserved time if you are more than 10 minutes late**.

What happens if you don't confirm your appointment within 24 hours of the scheduled time and/or you are late for your appointment?

- If you arrive for your appointment that has not been confirmed and/or you are more than 10 minutes late for your appointment, we promise to do our best to work with you to reschedule your appointment for routine health maintenance by finding the time that works best for you.
- Additionally, failure to comply with the Appointment Policy is a violation of our 24-Hour Cancellation Policy.

2. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, failing to cancel an appointment via phone or our patient portal, may be preventing another patient from getting much needed treatment.

As of January 1, 2020 if an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($75) fee; this will not be covered by your insurance company. Three No-Show appointments will subject you to possible dismissal from the practice.

3. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and healthcare practitioners on time.

If a patient is 10 minutes past their scheduled time for a primary care visit and/or shows up after their appointment time we will have to reschedule the appointment to a later time or date.

4. Controlled Substances

As a notice to all existing and potential new patients, we feel it is important to notify you that due to the Rules and Regulations for Healthcare Practitioners set forth by the Tennessee Board of Health, our healthcare practitioner does **NOT** prescribe scheduled II/III OPIATE medications on a long-term basis for the treatment of chronic conditions for any reason. This includes hydrocodone, oxycodone, morphine, fentanyl, methadone, oxymorphine, and hydromorphone.

_____	_____	_____
Print Name	Patient Signature/Guardian	Date

Continued on next page / other side

PATIENT REGISTRATION AND CONSENT FORM

PRELIMINARY INFORMATION

Referral Source	
Reason for Visit	
Date of Injury/Illness	
Injury/Illness is due to a work-related illness/injury: ❑ No ❑ Yes	

PATIENT PERSONAL INFORMATION

Full Legal Name	
Preferred Name	
Date of Birth	
Social Security Number	
Gender	
Mother's Maiden Name	

PATIENT CONTACT INFORMATION

Street Address	
City/State/Zip	
Email	
Home Phone	
Mobile	
Work Phone	

Appointment Reminder Contact Preferences
I authorize the following to receive automated appointment reminders: ❑ Home Phone ❑ Work Phone ❑ Mobile ❑ Email

EMERGENCY CONTACT INFORMATION

Full Name	
Relationship to Patient	
Street Address	
City/State/Zip	
Email	
Home Phone	
Mobile	
Work Phone	

ADVANCE DIRECTIVE
Current advance directives: ❑ Durable Power of Attorney ❑ Health Care Power of Attorney ❑ Living Will ❑ None

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PATIENT REGISTRATION AND CONSENT FORM

INSURANCE INFORMATION

Insurance Name	
Claims Address	
Claims Phone Number	
Effective Date	
Expiration Date	
Group Name	
Group ID Number	
Policy Number	

GUARANTOR/SUBSCRIBER INFORMATION (IF NOT SELF)

Full Legal Name	
Date of Birth	
Social Security Number	
Street Address	
City/State/Zip	
Email	
Home Phone	
Mobile	
Work Phone	
Employer	
Patient Relationship	

PROVIDE YOUR INSURANCE CARD(S) (PRIMARY, SECONDARY, ETC.) TO FRONT DESK AT CHECK-IN.

Authorization To Pay Benefits To Healthcare Practitioner: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my **Healthcare Practitioner** when s/he accepts assignment.

Authorization To Release Medical Information: I hereby authorize my **Healthcare Practitioner** to release any information necessary for my course of treatment.

I have reviewed the information above and made any necessary changes. _____ (patient/guardian initial)

_____ _____

Patient/Guarantor Signature Date

Continued on next page / other side

PATIENT NAME: _____

PATIENT REGISTRATION AND CONSENT FORM

CONSENT FOR FINANCIAL COMMUNICATION

Financial Agreement

- I, the patient, acknowledge, that as a courtesy, Scenic City Family Practice may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

Third Party Collections

I, the patient, acknowledge that Scenic City Family Practice may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO servicer") for medical account billing and servicing.

Assignment of Benefits

I, the patient, hereby assign to Scenic City Family Practice any insurance or other third-party benefits available for healthcare services provided to me. I understand Scenic City Family Practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Scenic City Family Practice, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefits

I, the patient, certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Scenic City Family Practice by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communication

I, the patient, agree that, in order for Scenic City Family Practice, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Scenic City Family Practice or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Scenic City Family Practice or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A printed or photocopy of this consent shall be considered as valid as the original.

_____ _____

Patient/Guarantor Signature Date

FINANCIAL POLICY

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be rescheduled. Scenic City Family Practice makes it a priority to verify proof of a patient's insurance, however, it is the patient's responsibility to know his/her benefits for all medical services including wellness benefits prior to time of service. Any balance left unpaid by insurance remains the patient's responsibility.

Insurance Processing

Please understand that payment of your bill is considered part of your services/treatment. The patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your co-pay or deductible which the insurance company is not liable for on the day of your visit. Insurance companies require Scenic City Family Practice to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to ⅓ of costly procedures or visit is required in advance for services not covered by the patient's insurance.

Self-Pay

Scenic City Family Practice contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company

Continued on next page / other side

PATIENT NAME: _____

unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received.

Outstanding Balances

Patients will be asked to settle any outstanding balances with Scenic City Family Practice before their next appointment. You may pay any outstanding balances at any time in our office or over the phone with credit card. Patients with outstanding balances may be declined treatment or triaged for non-emergency until the balance is resolved. Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance. As of January 2015, all unpaid balances 30 days after insurance processing will incur a 19% Interest Rate. Please pay balances to avoid interest being added to your account.

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs the Acknowledgement of Notice of Financial Policy agrees to pay addition collection processing fees of 30% of the original balance plus all costs associated with such collection activity, including interest incurred and reasonable attorney and court fees.

24-Hour Cancellation Policy

Scenic City Family Practice requires a 24-hours cancellation notice for all appointments as a courtesy to our staff and other patients needing medical attention. Please make sure to contact our office promptly if you need to cancel/reschedule your appointment. If we do not receive adequate notice, a $75 no-show fee will applied to your balance. THIS FEE WILL NOT BE BILLED TO YOUR INSURANCE. We understand that emergencies can occur and we will take that into account before applying any fees to your balance.

Payments

Scenic City Family Practice accepts cash, checks, Visa, AMEX, MasterCard, and Discover. There is a $30.00 fee for all returned checks.

Payment can be paid in person or mailed to:

SCENIC CITY FAMILY PRACTICE
5720 Uptain Road
Building 6100, Suite 4600
Chattanooga, TN 37411-5640

_____ _____

Patient/Guarantor Signature Date

ACKNOWLEDGEMENT OF NOTICE OF FINANCIAL POLICY

Patient Responsibility for Medical Service Charges

I, the undersigned, have read and understand Scenic City Family Practice's financial policy and agree to the terms. I authorize the release of any medical information necessary to process the payment of treatment to my insurance company, and request payment of benefits to Scenic City Family Practice. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I additionally agree that I will be responsible for payment in full of any co-pay at the time services are rendered as well as any deductible that may exist for said services.

I further agree that, should I be sent to collections for failure to pay for services rendered, I will be responsible for all reasonable fees and costs associated with collections, including reasonable attorney fees and court costs, and agree to pay interest on any charges sent to collections at the rate permissible by law.

_____ _____

Patient/Guarantor Signature Date

Continued on next page / other side

PATIENT NAME: _____

CONSENT TO ELECTRONIC/DIGITAL COMMUNICATION (EMAIL, VOICE AND/OR OR TEXT MESSAGE) USAGE FOR APPOINTMENT REMINDERS AND HEALTHCARE NOTIFICATIONS

Patients in our practice are contacted via email, voice and/or text messaging with appointment reminders, to obtain feedback on your experience with our healthcare team, and to provide general health reminders or information. SCFP does not charge for this service, but standard text messaging rates may apply as provided in the patient's wireless plan (contact wireless carrier for pricing details).

If at any time I, the patient, provide an email or phone number at which I may be contacted, I consent to to receiving appointment reminders and other healthcare communications or information via email, voice and/or text message from SCFP via the email and/or phone numbers or any email and/or phone number that I choose to forward or transfer my incoming electronic communication. I understand that this request to receive emails, voice and/or text messages will apply to all future electronic/ digital communication from SCFP unless I request a change in writing.

_____ _____

Patient/Guarantor Signature Date

HIPAA ACKNOWLEDGEMENT AND CONSENT

Notice of Privacy Practices/Clinics

I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/Clinics.

Communication About My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's healthcare operations purposes (e.g., quality improvement activities). I understand that the practice/ clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

NOTE: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard data, text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____ _____

Patient/Guarantor Signature Date

Continued on next page / other side

PATIENT NAME: _____

PATIENT REGISTRATION AND CONSENT FORM

PROTECTED HEALTH INFORMATION (PHI)

Disclosures to Friends and/or Family

IF YOU WISH TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER OR STAFF MAY DISCUSS YOUR MEDICAL CONDITION(S), PROVIDE THEIR NAME AND RELATIONSHIP TO PATIENT BELOW..

Release of Protected Health Information (PHI): List the full name, relationship and phone number for all individuals to whom our staff is PERMITTED TO SHARE OR DISCUSS your PHI.

Relationship to Patient	Legal Name	Relationship to Patient	Legal Name

I give permission for my Protected Health Information (PMI) to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed above.

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

_____ _____

Patient/Guarantor Signature Date

GENERAL PATIENT CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a Nurse Practitioner, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I, the patient, certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient/Guarantor Signature Date

Continued on next page / other side

PATIENT NAME: _____

HEALTH HISTORY FORM

SCFP | SCENIC CITY FAMILY PRACTICE

PAST MEDICAL HISTORY

Care Team Members

List all Heath Care Practitioners that you are currently seeing and have seen in the past.

Practitioner's Name, Address, and Phone Number	Practitioner's Comments
Dentist:	
Eye doctor:	

HISTORY OF PRESENT ILLNESS

Describe the major health concerns that you wish to address during this visit.

Health Concerns	Practitioner's Comments

Have you seen any other Healthcare Practitioners for this health concern? ❑ **Yes** ❑ **No**

List any other significant concerns that you are currently experiencing:

Personal Health History

Circle all of the illnesses you have been diagnosed with in the past.

Allergic rhinitis, seasonal Anemia Asthma Blood clots High blood pressure High cholesterol Cancer Chronic fatigue syndrome Diabetes Endometriosis Fibromyalgia	Gestational diabetes Glaucoma Heart disease HIV/AIDS Kidney stones Migraine Thyroid disease Seizures Sleep apnea Stroke	<u>Childhood Illnesses</u> Sickle cell anemia Recurrent ear infections Measles Mononucleosis ("Mono") Mumps Rubella ("German measles") Varicella ("Chicken pox") Diphtheria Pertussis Polio	Rheumatic fever Scarlet fever Congenital problems
Others:			

Continued on next page / other side

PATIENT NAME: _____

HEALTH HISTORY FORM

Surgical History

Select any previous surgeries by noting the approximate dates of these events

Month/Year	Surgery	Month/Year	Surgery
	Appendectomy (appendix removed)		Pacemaker placement
	Wisdom tooth extraction		Tonsillectomy (tonsils removed)
	Back/Spine surgery		Adenoidectomy (adenoids removed)
	Cholecystectomy (gallbladder removal)		Partial hysterectomy
	Cardiac catheterization		Total hysterectomy
	Heart bypass		Cesarian section
	Cardiac stent		Cesarian section
Other:			

Other Hospitalizations and Major Illnesses

Select all other previous hospitalizations or major illnesses and note the approximate dates of these events

Month/Year	Hospitalization Reason/Major Illness	Month/Year	Hospitalization Reason/Major Illness

Current Medications

List all medications which you currently take, including non-prescription medications, such as Tylenol, and over-the-counter supplements, vitamins and herbal products.

Medication	Strength, Preparation*	Dose	Frequency	Prescriber	Practitioner Notes
Example: Amlodipine	10 mg tablets	1 tablet	daily	J. Smith, MD	

Preparations: liquid, tablets, capsules, drops, injectable, inhaler, topical, patches, implant, suppositories.

Continued on next page / other side

PATIENT NAME: _____

HEALTH HISTORY FORM

SCFP | SCENIC CITY FAMILY PRACTICE

I understand that my appointment is subject to CANCELLATION and/or being RESCHEDULED to a later date **if I fail to completely provide the above information** on prescription and non-prescription medications and/or over-the-counter supplements, vitamins, and herbal products

Patient/Guarantor Signature ______________________ Date ____________

Preferred Pharmacy

Name	
Street Address	
Zip	
Preferred Prescription Quantity: ❑ 30-day supply ❑ 90-day supply	

Current Allergies

List all food and medication allergies.

Food/Medication	Reaction	Onset	Severity
		❑ Childhood ❑ Adulthood	❑ Mild ❑ Moderate ❑ Severe
		❑ Childhood ❑ Adulthood	❑ Mild ❑ Moderate ❑ Severe
		❑ Childhood ❑ Adulthood	❑ Mild ❑ Moderate ❑ Severe
		❑ Childhood ❑ Adulthood	❑ Mild ❑ Moderate ❑ Severe
		❑ Childhood ❑ Adulthood	❑ Mild ❑ Moderate ❑ Severe
		❑ Childhood ❑ Adulthood	❑ Mild ❑ Moderate ❑ Severe
		❑ Childhood ❑ Adulthood	❑ Mild ❑ Moderate ❑ Severe

Nutrition History

List any dietary restrictions, limitations, and intolerances:

SOCIAL HISTORY

Marital status	❑ Single ❑ Cohabiting ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
Preferred language	
Religion/Beliefs	

Academia/Occupational History

Employment status	❑ Full Time ❑ Part Time ❑ Not Employed ❑ Self Employed ❑ Retired ❑ Military Status
Employer	
Occupation/Position	
Student status	❑ Full Time ❑ Part Time ❑ Not a Student
Highest level of education	

Continued on next page / other side

PATIENT NAME: ______________________________

HEALTH HISTORY FORM

Household Members
List all others living in your home.

Relationship to Patient	Name	Relationship to Patient	Name

Reproductive/Sexual History

Sexual orientation	
Age of menses onset	
Age of menopause onset	
Number of children and ages	
Number of grandchildren	
Number of sexual partners (Lifetime)	
Number of sexual partners (Last 12 months)	
History of sexually transmitted infections	

At-Risk Behavior Screenings

Caffeine use: ❑ No ❑ Yes	Illegal drug use: ❑ No ❑ Yes	Tobacco use: ❑ No ❑ Yes

Alcohol Use Screening

How often do you have a drink containing alcohol?
❑ Never ❑ Monthly or less ❑ 2-4 times a month ❑ 2-3 times a week ❑ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?
❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more

How often do you have 6 or more drinks on 1 occasion?
❑ Never ❑ Less than monthly ❑ Monthly or less ❑ Weekly ❑ Daily or almost daily

Physical Activity Screening

How many DAYS of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?	days
On those days that you engaged in moderate to strenuous exercise, how many MINUTES on average, did you exercise?	minutes

Financial Resources Screening
Describe your difficulty paying for the very basics like food, housing, medical care, and heating
❑ Very hard ❑ Hard ❑ Somewhat hard ❑ Not very hard

Stress Level Screening
Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days? ❑ Not at all ❑ Only a little ❑ To some extent ❑ Rather much ❑ Very much

Continued on next page / other side

PATIENT NAME: _____

HEALTH HISTORY FORM

SCFP | SCENIC CITY FAMILY PRACTICE

Social Isolation and Connection Screening

In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?		times
In a typical week, how often do you get together with friends or relatives?		times
In a typical year, how often do you attend church or religious services?		times
Do you belong to any clubs or organizations such as church groups unions, fraternal or athletic groups, or school groups?	❑ No	❑ Yes

Exposure to Violence Screening

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex?	❑ No	❑ Yes
Within the last year, have you been afraid of your partner or ex?	❑ No	❑ Yes
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex?	❑ No	❑ Yes
Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex?	❑ No	❑ Yes

DEVELOPMENTAL HISTORY

Do you have any problems that make it hard for you to learn, such as hearing loss, poor eyesight, physical limitations or difficulty reading? If yes, describe:

PREVENTIVE CARE

Have you had the following screenings?	**No**	**Yes**	**If yes, when?**	**Practitioner's Comments**
CT screen for lung cancer				
Stress test for heart				
Stool test for colon cancer				
Colonoscopy				
Flexible sigmoidoscopy				
Digital rectal exam to examine prostate				
PSA blood test for prostate				
Mammogram				
Pap/Pelvic exam				
Bone density test (DEXA scan)				

Immunizations have you been given:	**No**	**Yes**	**If yes, when?**	**Practitioner's Comments**
Tetanus				
Influenza (flu)				
Prevnar/PCV13 (pneumonia)				
Pneumovax/PPSV23 (pneumonia)				
Hepatitis B				
Zoster (shingles)				
Varicella (chicken pox)				

Continued on next page / other side

PATIENT NAME: _____

HEALTH HISTORY FORM

REVIEW OF SYSTEMS

Circle the symptoms that you are experiencing

General
Weight change
Fever
Fatigue
Chills
Night sweats
Appetite change
Sleep problems

Skin
Itching
Rash
Mole change
Hair change
Color change
Non-healing sores

Eyes
Vision change
Double vision
Pain
Spots / Floaters
Itching
Watering
Redness

Ears
Earpain
Hearingloss
Use of hearing aid
Ringingin ears

Nose
Nose bleeds
Congestion
Runny nose
Itching
Sinus problems

Mouth & Throat
Teeth problems
Mouth sores
Sore throat
Difficulty swallowing
Hoarseness

Neck
Lump
Swollen glands
Pain

Breasts
Lump
Pain
Nipple discharge

Lungs
Cough
Wheeze
Shortness of breath
Sputum
Coughing up blood

Heart/Vessels
Chest pain
Swelling feet/legs
Palpitations
Murmur
Calf pain with walking
Varicose veins
Easy bruising / bleeding

Stomach
Heartburn
Nausea/ Vomiting
Diarrhea
Constipation
Bowel changes
Bloody stools
Black stools
Abdominal pain
Excessive gas/belching
Hemorrhoids

Urinary
Burning
Frequent urination
Painful urination
Blood in urine
Reduced urine flow
Hesitancy
Dribbling
Wake up to urinate
Incontinence

Muscle/Skeleton
see pain assessment
Joint pain
Joint swelling
Joint redness
Neck pain
Back pain
Muscle pain

Neurological
Paralysis
Seizures
Fainting
Muscle weakness
Balance problems
Coordination problems
Numbness
Tremors
Memory changes
Headache

Female Reproductive
Abnormal vaginal bleeding
Vaginal discharge
Vaginal dryness
Vaginal itching
Painful intercourse
Painful periods
PMS
Hot flashes / Night sweats
Problems with sex
Genital sores
(G: P: AB: SAB: LC:)

Male Reproductive
Discharge from penis
Sores on penis
Testicular pain
Testicular lump
Problems with sex
Erection problems
Prostate problems

Emotional
Depression
Loss of sleep
Nervousness
Anxiety
Stress
Trouble concentrating

Vision	❑ Glasses ❑ Contacts ❑ Reading glasses only
Dominant hand	❑ Left ❑ Right ❑ Ambidextrous

Continued on next page / other side

PATIENT NAME: _____

HEALTH HISTORY FORM

Patient Health Questionnaire (PHQ-9): Depression Screening

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all (0 days)	Several days (2-7 days)	More than half the days (8-11 days)	Nearly every days (12-14 days)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling/staying asleep, sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television.				
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.				
Thoughts that you would be better off dead or of hurting yourself in some way.				

FAMILY HEALTH HISTORY

FAMILY HEALTH HISTORY If yes, indicate applicable illnesses for each of your relatives by placing an "✘" under the illnesses on the line for that relative.	Heart disease	Stroke	High blood pressure	High cholesterol	Diabetes	Thyroid disease	Osteoporosis	Breast cancer/s	Other cancer/s	Depression	Alcoholism	Drug abuse	Other mental health disorder/s	Suicide
Mother														
Father														
Maternal Grandmother														
Maternal Grandfather														
Paternal Grandmother														
Paternal Grandfather														
Sibling: ❑ Male ❑ Female														
Sibling: ❑ Male ❑ Female														
Sibling: ❑ Male ❑ Female														

PATIENT NAME: _____