SOUTHWEST FAMILY PHYSICIANS COMPREHENSIVE INITIAL HEALTH HISTORY

NAME_____AGE_____DATE_____BIRTHDATE_____
How did you hear about us?_____
Why are you seeing us today?_____
Briefly describe your present symptoms (if any) _____
_____
Please list any other physicians you are seeing and what you are seeing them for. _____
_____

Please review the following & circle any problems you have had or are currently having.

Please provide details: dates, duration & Doctors seen, if possible

Problems with eyes, ears, nose, throat, sinuses, severe infections, nosebleeds, hearing loss, ringing in ears, bleeding gums, Swollen glands, prolonged hoarseness, difficulty swallowing?
Dizziness, fainting, seizures, severe headaches, stroke, tremor, weakness, numbness?
Persistent cough, spitting blood, bronchitis, pleurisy or pneumonia, asthma, emphysema, tuberculosis, shortness of breath (lying flat or with exertion) wheezing or allergies?
Chest pain, irregular beats, high blood pressure, rheumatic fever, heart murmur, heart attack, swollen ankles or hands, high cholesterol or hardening of the arteries?
Diseases of the stomach, intestines, liver or gall bladder: persistent nausea or vomiting, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, black or bloody bloody stools, recurrent heartburn, pain, constipation, diarrhea, or change in bowel habits?
Sugar, protein or blood in urine, kidney stones or disease, frequent bladder infections, urine leakage or pain, prostate or genital problems, decrease in force of stream?
Diabetes, thyroid or other endocrine disease? Goiter? Excessive thirst or urination?
Back pain, sciatica, rheumatism, arthritis, gout or problems of the muscles, bones or joints?
Deformity, lameness or amputation? Any history of upper body irradiation?
Skin problems: skin cancer, lumps, hives, eczema, psoriasis, large dark irregular or changing moles, jaundice, varicose veins, itching, non-healing sores or other rashes?
Bleeding disorders, blood clots, anemia, or easy bruising? Any blood transfusions?
Physical or sexual abuse?
Significant changes in weight or appetite in the last few years? Overweight or underweight?
Problems with severe fatigue, especially during the day? Frequent fevers or chills?
Measles, mumps, chicken pox, polio, rheumatic fever, TB, mononucleosis or AIDS?
Accidents, fractures, injuries or emergency visit? Toxic exposures? X-rays taken?
Gonorrhea, herpes, Chlamydia, genital warts, penile discharge or other sexually transmitted disease?
Any problems with menstruation, menopause or pregnancy or with abnormal periods, irregular bleeding, nipple discharge, abnormal PAPS or mammograms?
Problems with infertility, pregnancy, delivery or nursing of children?
Psychiatric disease, depression, suicidal, excess anxiety or moodiness, memory loss?
Any mental or physical disease, hospitalization, consultation, injury or surgery not listed?
Requested or received benefits, payment, or been off work due to injury or disability?
Have you been advised to have hospitalization or surgery which was not done?
Have you had a military deferment, rejection or discharge due to a medical condition?

NAME_____

Please list all **MEDICATIONS** you are currently taking or have taken over the past month. Include aspirin or products containing aspirin, vitamins and any over-the -counter medications such as laxatives or antihistamines taken irregularly.
Please use the other side for more space, if needed, and **so indicate.**

MEDICATION DOSE TAKEN HOW OFTEN? WHAT FOR?

_____
_____
_____
_____
_____
_____

Please list any **ALLERGIC REACTIONS** to medications in the past.

MEDICATION WHAT HAPPENED WHEN YOU TOOL IT?

_____
_____
_____

FAMILY HISTORY

	Age, if living	Health Problems	Age at death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Children				

Any other family history (include grandparents, uncles, and aunts) of tuberculosis, epilepsy, migraines, thyroid disease, goiter, blood pressure, stroke, diabetes, bleeding disorder, leukemia, alcoholism, heart or kidney disease, mental illness, suicide, arthritis, gout, osteoporosis, asthma, allergies, glaucoma, colitis, colon polyps, skin, colon, breast or other cancer?

Please provide details of which relatives had which problems.

_____
_____
_____

FAMILY PLANNING & SEXUAL HISTORY (Men and Women) Current Birth Control Method: _____

Have you ever had sexual intercourse? ……..... N Y
Do you sometimes have sex without birth control?…….....N Y
Do you sometimes have sex without protection from sexually transmitted diseases? ……N Y
Is your birth control method unsatisfactory? Would you like to change it? ……N Y
Does your sexual partner have pain or discharge from their vagina or penis, any urinary problems or abnormal pap smears? …….....N Y
Do you want to be checked for sexually transmitted diseases or HIV (AIDS)? ……N Y
Any questions or concerns regarding sex or birth control? …….....N Y
Are you worried about getting pregnant before you're ready, making someone else pregnant or being pressured to have sex? …….....N Y
Are you worries about being infertile? …….....N Y
Are you or your partner currently trying to get pregnant or planning to try? ……N Y
Have you had a new partner in the past 3 months? …….....N Y

Past methods you have tried (circle): Pill, Diaphragm, IUD, Norplant, Shots, condoms, foam sponge, Rhythm.

Total number of partners in the last 3 years? _____ How long have you been exclusively monogamous with your current partner? _____
Age you first had intercourse? _____

NAME_____

HEALTH MAINTENANCE HISTORY / PREVENTATIVE MEDICINE

Has it likely been 10yrs since your last Tetanus shot? …….N Y
Should we check you cholesterol, or do you want it checked? ……N Y Date of last check_____level_____
Would you like to get annual flu shots? …….....N Y
Are you concerned that you are: (circle) too tall; short; thin; fat; or breasts too big;
breast to small; penis too small? …….....N Y
Are you sometimes so sad and anxious that you think about dying?…….N Y
Are you worried about relationships at home, work, or family? ……N Y
Any family illness, changes, move or crises? …….....N Y
Are you worried about your health in general? …….....N Y
Any problems falling asleep or staying asleep? …….....N Y # hrs sleep per night? _____

Approximately how many years has it been since your last:

Chest x-ray? _____ EKG or Electrocardiogram? _____ Complete eye exam? _____ TB skin test? _____
Colon cancer screening by hem occult cards? _____ By Colonoscopy or Flexible sigmoidoscopy? _____
Complete physical? _____Rectal exam _____(Men only) Testicular exam? _____
Do you do monthly testicular exams? _____ Pneumonia shot? _____ Hepatitis shot? _____

HABITS

Are you mostly sedentary or not doing any formal exercise? ……N Y # hrs formal exercise per wk: _____
Do you smoke cigarettes or pipe? …….....N Y # packs per day: _____
Do you drink alcohol? …….....N Y Avg. # drinks per day: _____
Has anyone ever told you to cut back on your drinking? ……N Y
Do you routinely add salt to your food while cooking or at the table? ……..N Y
Do you drink coffee, tea, chocolate, soda or other caffeinated drinks? …….N Y Avg # drinks per day: _____
Do you ever use any street drugs or non-medical substance? ……N Y Multivitamins? _____ Iron? _____
Do you eat black licorice regularly? …….....N Y
Do you travel without a seat belt or bicycle helmet? …….N Y Calcium? _____Fluoride? _____

SOCIAL HISTORY This information is often helpful for us. It is confidential. Answering is optional.
Marital status (please circle): Never Married Single Divorced Married Separated Significant Other For ____ yrs.
Sexual orientation: your partners are or have been(please circle): male female both (please circle): exclusively usually
Name of Spouse or "S.O.": _____
Names and dates of birth of children:
_____
_____
_____
_____
_____
Total years of your schooling: _____ Degrees: _____
Currently working? Y / N Employed as: _____
What does this mean you do, actually? _____
Previously employed as: _____
Hobbies / volunteer work: _____ Pets: _____
Religious affiliation: _____

NAME _____

FEMALE HISTORY (FOR WOMEN ONLY)

Date of last pap smear? _____
First day of last menstrual period? _____

Have your last menstrual periods in any way been unusual (shorter, lighter, early or late)?..N Y
Could you possibly be pregnant or do you think we should check? …….N Y
Any problems with your menstrual cycle (circle):
Severe cramps, or PMS, very heavy flow, spotting between periods or after sex? …….N Y
Did your mother take DES hormone during her pregnancy with you? ……..N Y Don't know
Do you have any history of abnormal PAPS? …….....N Y
Do you have any pelvic pain, pain during sex or urination? …….....N Y
Do you think or know you've reached menopause? …….....N Y Hormone replacement medication? Y / N
Do you have (please circle): urine leakage, night sweats, vaginal dryness, trouble sleeping,
Severe mood swings, hot flashes? …….....N Y
Any unusual vaginal discharge, itching, odor or burning? …….....N Y
Any problems with recurrent yeast or urinary tract infections? ……N Y
Any history of pelvic or sexually transmitted diseases? …….....N Y
(circle): herpes, genital warts, gonorrhea, Chlamydia, trichomonas?

Last mammogram: _____

BREAST CANCER ASSESSMENT

Last breast exam: _____

Do you have any family history of breast or ovarian cancer? …….N Y
Do you have any questions on or need help with self breast exam? ……N Y
Any breast cancer, lumps, biopsies or abnormal mammograms? ……N Y
Any nipple discharge, breast or nipple pain? …….....N Y
Were you less than 12 years old when your period started? ……...N Y
Were you older than 30 when you had your first child? …….....N Y
Were you older than 50 when you started going through the change? ……N Y
Total # of months spent pregnant: _____ spent breast feeding: _____

SOUTHWEST FAMILY PHYSICIANS PATIENT REGISTRATION

Please answer all questions

PATIENT INFORMATION

Date _____ Account# _____

Name _____
Last First Middle

Address: _____City: _____ST: _____Zip: _____

Phone # ( ) _____ S.S. # _____DL # _____

Birth date: _____ Sex: _____ Referred by: _____

Employer: _____ Work phone # ( ) _____

If patient has ever been known under another name, list_____

Spouse Name: _____Spouse Employer: _____

Please give full name of person to contact in case of emergency, preferably the name of a person who does not live with you.

Name: _____Relationship to Patient _____

Address: _____ Phone # ( ) _____

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT,COMPLETE THE FOLLOWING

Name _____
Last First Middle

Address: _____City: _____ ST. _____Zip: _____

Phone # ( ) _____ S.S. # _____ DL # _____

Employer: _____ Work phone # ( ) _____

Occupation: _____Relationship to Patient: _____ Birth date _____

INSURANCE INFORMATION

INFORMATION MUST BE COMPLETED FOR INSURANCE COMPANY TO BE BILLED

PRIMARY INSURANCE INFORMATION

Insurance Company Name _____ Phone # _____

Claim Address _____

Policy Holder _____

Policy Holder Employer _____ Effective Date _____

ID # _____Birth date: _____/_____/_____ Group # _____Co-Pay_____

FAMILY MEMBERS

	Birth date	HOME #	WORK #
1. Self			
2. Souse			

	SCHOOL NAME	SCHOOL #
3. Child		
4. Child		
5. Child		

I give permission to leave a message at (circle) Home Work None

Signature_____

THERE WILL BE A $25 FEE FOR MISSED APPOINTMENTS

SOUTHWEST FAMILY PHYSICIANS
CONDITIONS OF TREATMENT

1. **Consent to Treatment:** The undersigned hereby consents to the administration and performances of all diagnostic procedures and treatment which, in the judgment of my physician, may consider necessary or advisable.
2. **Release of Information:** The clinic will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the clinic is permitted or required to by law to release information. I certify that my records may be released to my primary care physician upon request. The undersigned agrees that to extent necessary to determine liability or payment, and to obtain reimbursement, the clinic may disclose portions of the patient's record, including his/her medical records to any person or corporation which is or may be liable, for all or any portion of the clinic's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carriers. Special permission is necessary to release this information where the patient is being treated for alcohol or drug abuse.
3. **Medicare alignment:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.
4. **Assignment of insurance benefits:** in the event I am entitled to insurance benefits arising out of any policy of insurance insuring me or any party liable to me I herby assign said benefits directly to this clinic for application to my bill. I agree that the clinic may issue a receipt for such payment that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment and that I shall be responsible for all charges not covered by this agreement.
5. **Financial Agreement:** I herby agree that in consideration for services rendered by the clinic, I shall make prompt payments to the account to the clinic as bills are presented. I agree to pay interest at legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney for collection. I shall pay the actual attorney's fees and collection expenses.

I agree to the above conditions of treatment and understand that I will be required to sign the one time and this will be kept as part of my permanent file.

_____

Signature of patient, parent, or guardian Date

_____

Legal relationship to patient

Regarding Insurance Coverage for Your Care Here

To help you understand insurance billing polices, we have outlined these tips. Knowing these issues up front can save you time, hassle, and finances. In addition, it allows us to focus on your medical care. Our aim is for your total office experience to be as effective and pleasant as possible.

Being a family practice clinic, we have a wide scope of care. We can take care of many health care needs right here - whether you need Preventive Wellness Screening, General Medicine, Pediatric care, Obstetrics, Gynecology or office surgeries.

You will be responsible for visits or procedures that your insurance company denies as "not covered" or "excluded" Many plans will not pay for Preventative Care (physicals, well - women exams, Pap smears, etc). You may be surprised at what your insurance considers "mental health" ("tiredness" or "stress" for example).

We will strive always to do our best to help you, however, we cannot re-bill charges with changed diagnosis codes just to "get it through" your insurance. This may be considered fraudulent by insurers and subjects the entire clinic to audits. Your presenting complaint becomes important in determining whether you are seen and billed as a Wellness/Preventative Medicine exam (such as a Physical, Pap. Etc) or as a problem-oriented exam (such as toe nail fungus, irregular periods, etc). Please note that these are two, distinct types of visits. We cannot do justice to your medical needs if we try to roll preventive care together with significant problem solving and we are required to bill for each separately, using mutually exclusive codes. we know many patients are frustrated by this - but we have no influence over the insurance regulations and we hope you understand that asking us to "manipulate the system" compromises our ability to simply focus on providing you good medical care. Consider that if your insurance covered everything you would doubtless have to pay a higher premium, deductible, or co-pay.

We accept most insurance plans and , as a courtesy, we will file your insurance claim for you. However, since there are hundreds of different types of insurance plans, we cannot bend individual charges for each different plan, patient, or visit (there are over 1,400 different insurances in our computer system!). We encourage you to familiarize yourself with your own plan prior to scheduling your office visit with us: what services are covered, what prior authorizations or pre-certifications are needed? If your insurance company does not pay as expected, **please call their customer service department directly** as we are unable to guarantee your insurance benefits.

We request payment for office services at the time of your visit. We accept cash, checks, and most major credit cards and we can bill your health insurance plan for you provide us with a copy of your insurance card. Please register at the front desk at each visit and update any address, phone, or insurance changes at that time. Even if you have been coming here a long, **we will need to see a copy of your insurance card at every visit.** this is because small details change from time to time and cards expire: we would rather get things billed correctly for you the first time.

Bills that are unpaid may be charged a monthly finance charge. To avoid a charge and let other patient's urgent needs be worked in please notify us at least 24 hours in advance if you need to reschedule your appointment.

Please feel free to call our Patient Accounts Representatives at 503-597-1201 if you have any questions about your account here.

Signature _____ Date _____

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize southwest Family Physicians to **use and disclose** the health and medical information of _____ for the purpose of **Treatment, Payment, and health care operations.**
(Name of Patient)

* **Treatment** (includes activities performed by a physician, nurse, office staff, and other type 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 coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of of health care services for medical necessity, justification of charges, recertification and preauthorization).
* **Health Care Operations** (include the necessary administrative and business functions or our office).
* **I give my consent to release Health information to: _____**

You may review Southwest Family Physicians " **Notice of Privacy Practices " for** additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms Contained in the **Notice** may change also. A summary of the **Notice** will be posted in the lobby of our Office indicating the effective date of the **Notice** in the upper right hand corner. We will offer you a copy of The **Notice** on your first visit to us after the effective date of the then current Notice. We will also provide You with a copy of the **Notice** upon your request.

As more fully explained in the **Notice,** you have the right to request restrictions on how we use and disclose Your protected health information for treatment, payment, and health care operations purposes. **We are not Required to agree to your request.** If we do agree, we are required to comply with your request unless the Information is needed to provide you emergency treatment. Other physicians who call coverage for our office Are required to use and disclose your protected health information consistent with the **Notice.**

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent Southwest Family Physicians has already used or disclose the information in reliance on this CONSENT.

_____ _____
(Date) (Signature of patient)

Or

_____ _____
(Date) (Signature of Person Responsible for Patient)

_____
(Relationship to Patient)