Comprehensive Health Questionnaire

☐ New Patient ☐ Annual Exam

Name_____ Date of birth_____

Today's date/date completed_____ Preferred phone #_____

Preferred Pharmacy (include name + location)_____

Please describe what problem or concern brought you to our office today:_____

_____

Special Communication Needs: Requires Updating Annually			
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	☐ Yes ☐ No		
Hearing impairment	☐ Yes ☐ No	Cognitive impairment	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	Sensory impairment	☐ Yes ☐ No
Language preference:		Other:	

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions			
Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
		☐ Opioid dependency	

Personal Health History		Previous Surgical Procedures	
No Change Since Previous Year ☐		No Change Since Previous Year ☐	
Please check past or current problems or conditions		Please check if you have had any of the following	
Condition	Condition	Procedure	Year
☐ Hypertension	☐ Seizures	☐ Heart surgery	
☐ High cholesterol	☐ Headaches	☐ Carotid artery surgery	
☐ Diabetes	☐ Stroke	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	
☐ Congestive heart failure	☐ Urinary tract infections	☐ Gallbladder removed	
☐ Asthma	☐ Osteoarthritis	☐ Appendix removed	
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesophageal reflux disease	☐ Bleeding disorder	☐ Breast cancer surgery	
☐ Stomach ulcer	☐ Addiction Issues	☐ Prostate cancer surgery	
☐ Kidney problems	☐ Depression or anxiety	☐ Hernia	
☐ Liver disease/hepatitis	☐ Mental Illness	☐ Pacemaker	
☐ Colon cancer	☐ Other (please describe)	☐ Other (please describe)	
☐ Bowel/digestive problem			

Specialty Providers: Requires Updating Annually	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐ Eye doctor	☐ Nephrologist
☐ Cardiologist	☐ Psychiatrist
☐ Oncologist	☐ Allergist
☐ Urologist / Gynecologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other
☐ No new specialist visits since previous year	

Please list any current medications below: (Please note that LifeWay Health providers will not prescribe any chronic pain medications)	

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below

Are you unable to fill your prescription(s) because of the cost	**☐ Yes**	**☐ No**
Are you unable to fill your prescriptions because of lack of transportation	**☐ Yes**	**☐ No**
Have you ever applied for any pharmacy assistance	**☐ Yes**	**☐ No**

Allergies:	
Please list any allergies to medications or foods	

Social History:

Please circle appropriate answers below and provide explanations where appropriate

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Have you had CHANGE in Marital Status: ☐ No ☐ Yes If yes, describe below:

Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or >

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation
How stressful would you rate your job situation: (Circle number)

Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

How stressful would you rate your current living situation: (Circle number)
Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Do you fear for your safety in your current living situation? ☐ No ☐ Yes If yes, describe below:

Are there financial concerns that affect your ability:
1) to go to the doctor ☐ No ☐ Yes If yes, describe:

2) to obtain food and shelter ☐ No ☐ Yes If yes, describe:

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?
☐ No ☐ Yes If yes, describe:

Current Health Concerns

Please check problems or conditions that you are **CURRENTLY** experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	**Pain, weakness, or numbness in**		Number of pregnancies
☐ Vomiting	☐ Arms ☐ Hips ☐ Back		Miscarriages
☐ Vomiting blood	☐ Legs ☐ Neck ☐ Shoulders		Birth control method
☐ Change in bowel habits	☐ Hands ☐ Feet		

Health Literacy Questionnaire:

It is really important to your provider that you understand the information related to your health. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree

I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	**1 2 3 4 5 6 7 8 9 10**
I feel that I remember the instructions given to me at my doctor's office when I get home	**1 2 3 4 5 6 7 8 9 10**
I feel that I have a strong understanding of medical language	**1 2 3 4 5 6 7 8 9 10**

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations			Year	Tests			Year
Tetanus vaccine / Tdap	☐ Yes	☐ No		Pap smear/pelvic	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No		Mammogram	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No		Bone dexascan	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No		Colonoscopy	☐ Yes	☐ No	
				Prostate test	☐ Yes	☐ No	

Additional Vaccines taken since previous year ☐ Yes ☐ No

If yes, list vaccine name and date:

Health Behaviors: *Requires Updating Annually for 11 years and older*			
Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker			
If current smoker how many packs per day for how many years_____			
Alcohol intake: ☐ No ☐ Yes If yes how many drinks/how often_____			
Have you or are you currently taking an Opioid medication (ex: morphine, hydrocodone, oxycodone, oxycontin, dilaudid, fentanyl)?	☐ Yes ☐ No		
If yes, Did you utilize non-medication treatments for your pain before taking medication? (Heat/Cold/Physical Therapy/)	☐ Yes ☐ No		
Illicit drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current			
If Past or Current drug use describe:			
Exposure to secondhand smoke	☐ Yes ☐ No	Wear a seatbelt	☐ Yes ☐ No
Eat a diet high in fruits and vegetables	☐ Yes ☐ No	See a dentist at least once a year	☐ Yes ☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes ☐ No	Wear sunscreen	☐ Yes ☐ No

Mood Screening: *Requires Updating Annually for age 11 and up*	
A person's mood can have a strong influence on their health status and overall wellbeing. Over the past 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Urinary Incontinence Assessment: *Requires Updating Annually for 65 years and older*				
Do you experience leaking in the following situations:	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐

Fall Risk Screening: *Requires Updating Annually for 65 years and older*	
In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Functional Assessment: *Requires Updating Annually for 65 years and older*				
Do you need assistance in the following areas?	Not at all	A little	Sometimes	A lot
Bathing, dressing and grooming	☐	☐	☐	☐
Daily activities (cooking, cleaning other household tasks)	☐	☐	☐	☐
Walking or driving	☐	☐	☐	☐
Communicating needs and feelings	☐	☐	☐	☐
Understanding directions	☐	☐	☐	☐
Keeping appointments, taking medications and performing other medical treatments	☐	☐	☐	☐
If yes to any of these questions, who helps with these activities?				

Financial Policy

Your insurance contract is an agreement between you, your insurance company and in any instance, your employer. The financial side of medical practices has become increasingly complex over the past few years with the advent of managed care and the many different types of insurance plans now available. We try our best to be familiar with the regulations and restrictions of each company, though you, the patient, are ultimately responsible for understanding the details of your own health care coverage. The following are the guidelines we use to regulate the financial side of our practice. Please make yourself familiar with these and let us know if you have any questions.

1. All charges are due at the time of service unless other arrangements have been made in advance.
2. Medicaid Co-Pays will be collected at the time of service in accordance with Carolina Access Policy which states "failure to make co-pays will result in dismissal"
3. Patients with third party insurance plans which require their own co-pay at sign in. Failure to do may result in the patient not being seen by the provider unless it is a genuine medical emergency. We will gladly bill your insurance company for the remainder of the charges associated with your visit. Please be aware that there may be an additional balance even after your insurance payment due to your deductible and/or any non-covered services. If so, our Billing Supervisor will notify you, and the additional charges will need to be paid within 30 days of receipt of your bill.
4. We are not contractually required to file claims for Medicare Secondary plans; however, we will file them once as a courtesy. Should the company not respond within 45 days of our filing, then the charges will be sent to you directly and you will be responsible for them as with any other charges.
5. While we always see patients for emergency care, routine care will only be given to patients whose accounts are current or have made financial arrangements with us maintaining the conditions thereof.

I have read and understand that financial policy of LifeWay Health. My signature below acknowledges that any questions I may have regarding the policy have been fully explained and answered.

Patient Name: _____Signature: _____

Date: _____

Designated Individuals' Authorization

(HIPAA Compliance)

In order to protect your patient confidentiality, we need to know if there is a phone number (with voicemail) for you where we can leave the results of your laboratory tests or other sensitive information. Please indicate the information below, and we will keep this in your file until you instruct us in writing to remove it.

I give LifeWay Health employees permission to leave confidential health care information for me at the following phone numbers(s):

_____ (if none, please note)

_____ (if none, please note)

_____ (If none, please note)

I understand these numbers will be used until I notify LifeWay Health in writing if they should no longer be used.

I authorize the following people to receive information regarding my medical status (including access to my medical records) and financial records ongoing.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Signature: _____ **Date:** _____

Appointment Cancellation Policy

Here at LifeWay Health, we are committed to providing quality health care for each patient and we respect your time and make every effort to keep you from waiting. As a result, your appointment time is reserved for exclusively you. Please read and sign our updated policy regarding patient responsibilities.

How To Cancel or Reschedule Your Appointment

We ask that you contact our office **at least 24 hours** in advance to cancel or reschedule your appointment. Appointments are in high demand and your early cancellation will give another patient the opportunity to receive care.

No Show Policy

A "no show" appointment occurs when a patient misses an appointment entirely.

If you "no show" an appointment, we may ask you to place a credit card on file to reschedule another appointment. Continuing to no show appointments may result in a fee up to $50.00 and/or possible dismissal from the practice.

Late Arrival Policy

If you arrive 15 minutes after the start of your appointment, we may have to reschedule your appointment.

I have read and understand the cancellation and payment policy and agree to abide by its guidelines.

Signature:_____ Date: _____