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

No Change Since Previous Year ☐

Please check past or current problems or conditions

Condition	Condition
☐ Hypertension	☐ Seizures
☐ High cholesterol	☐ Headaches
☐ Diabetes	☐ Stroke
☐ Heart attack or angina	☐ Prostate problem
☐ Irregular heart rhythm	☐ Breast problem
☐ Congestive heart failure	☐ Urinary tract infections
☐ Asthma	☐ Osteoarthritis
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)
☐ Pneumonia	☐ Thyroid problem
☐ Gastroesophageal reflux disease	☐ Bleeding disorder
☐ Stomach ulcer	☐ Addiction Issues
☐ Kidney problems	☐ Depression or anxiety
☐ Liver disease/hepatitis	☐ Mental Illness
☐ Colon cancer	☐ Other (please describe)
☐ Bowel/digestive problem	

Previous Surgical Procedures

No Change Since Previous Year ☐

Please check if you have had any of the following

Procedure	Year
☐ Heart surgery	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Tonsillectomy	
☐ Joint replacement	
☐ Breast cancer surgery	
☐ Prostate cancer surgery	
☐ Hernia	
☐ Pacemaker	
☐ Other (please describe)	

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?				

7 Yorkshire Street
Suite 201
Asheville NC 28803
828.761.1710
Fax-828.505.8345

Designated Individuals' Authorization- HIPAA Compliance

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 test 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 Dogwood Family Medicine employees permission to leave confidential Healthcare information for me at the following phone number(s):

If none please note:

____

____

____

I understand these numbers will be used until I notify Dogwood Family Medicine in writing if they are no longer to 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

Patient Name: ______________________________ **Date of Birth:** ____________

Signature: ______________________________ **Date:** ____________

7 Yorkshire Street
Suite 201
Asheville NC 28803
828.761.1710
Fax-828.505.8345

Office and Financial Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance about our office policies allows for a good flow of communication and enables us to achieve our goal. ***Please read each section carefully and initial.*** **If you have any questions, please ask a staff member.**

Appointments

1- We value the time we set aside for each patient. We do not double book appointments. If you are not able to keep your appointment, we would appreciate 24-hour notice. **There is a charge of $50 for missed appointments. ($100 for missed ultrasound appointments)** this charge is not filed to insurance and will be *patient* responsibility.
2- If you're late for your appointment (>15 minutes), we will do our best to accommodate you. However, in certain situations, it may be necessary to reschedule your appointment.
3- We strive to minimize any wait time; however, emergencies do occur and will take priority of rescheduled visits. We appreciate your understanding.
4- Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a wellness visit.

Initial: ________

Insurance Plans

Please understand that our office files insurance as a courtesy to our patients.

1- It is your responsibility to keep us updated with your correct insurance information. **If the insurance company, you designated is incorrect you will be responsible for payment of the visit.** We MUST have a copy of your insurance card on file to file a claim. Please be prepared to present your insurance card at each visit if necessary. **If you do not have a card or your policy is not current/active you will be responsible for payment of the visit.**
2- Some insurance companies require you to specify primary care physician. If we are your primary care physician, make sure Raleigh Durham Medical Group Associates appears on

your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.

1- You are responsible for understanding your benefit plan regarding covered services and participating Laboratories. For Example:
    a. Not all plans cover annual healthy (well) physicals, sports physicals, vision screenings and other services. If these are not covered, you will be responsible for the payment.
2- It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial:________

Financial Responsibility

1- According to your insurance plan, you are responsible for all co-payments, deductibles and co-insurances.
2- **Co-payments, coinsurance percentages and deductible estimates** are due at the time of service. For patients with deductibles to meet, we collect $50 up front because it is almost impossible to know the allowable amounts for each insurance policy- charges are then filed and an additional bill may be sent based on the insurance assessment of the claim.
3- Self-pay patients are expected to pay for services in FULL at the time of visit. A 25% discount is applied for self-pay patients.
4- If we do not participate in your insurance plan, full payment is expected from you at the time of your visit.
5- Patient balances are not to exceed $100 before additional attempts at collection may be made. We cannot extend credit or allow large balances to build. If a balance exceeds $100, payment will need to be made towards that balance prior to future appointments.
6- We accept cash, checks, Visa and MasterCard, American Express, Discover credit and debit cards.
7- A $35 fee will be charged for any tax return for insufficient funds.

Initial: ______

Forms

1- There is a $15 per page fee for any forms that are filled out by our providers/staff outside of an office visit. Forms exceeding five pages will be charged based on the time taken to complete the forms.

Initial: ______

Medical Records

1- For your protection all medical records require a signed consent before they can be released to or received from another party.

Initial: ______

Prescription Refills

1- For medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly. Due to the high volume of medication refills/request, we ask that you contact your Pharmacy to verify the prescription has been completed.

Initial: ______

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name: ______________________________

Patient Signature ______________________ **Date** ______________

If patient is a minor:

Parent/Guardian Name: ______________________ **Relationship:** __________

Parent/Guardian Signature ______________________ **Date** ______________