valley MED @ the ten
FAMILY & GENERAL PRACTICE

www.valleymedpc.com
10 Coburg Road, Suite 201
Eugene, OR 97401
P: 541-687-8581
F: 541-343-1411

Hello _____,

Welcome to Valley Med @ the ten! We look forward to caring for you!

As your primary care home, we will:

- ✓ Better coordinate your care to help get you the services you need, when you need them.
- ✓ Listen to your concerns and answer your questions.
- ✓ Help you play an active role in your health.

A Patient-Centered Primary Care Home (PCPCH) is a health clinic that is recognized for their commitment to patient-centered care. Just as it sounds, patient-centered care is all about you and your health!

We will make prevention and wellness a top priority. If you have a special health concern or condition, your health care team will help connect you with other health professionals to get you the care you need. Your team is led by your primary care provider.

Team: Brittany Alloway, DO
Medical Assistant: Claudia
Reception: Leona, Danielle
Referral Coordinator: Kara

Team: Laurel Merz, FNP
Medical Assistant: Megan
Reception: Leona, Danielle
Referral Coordinator: Kara

Team: Benjamin Houston, PA-C
Medical Assistant: Laura
Reception: Leona, Danielle
Referral Coordinator: Kara

Team: Ralph Taguba, PA-C
Medical Assistant: Juli
Reception: Leona, Danielle
Referral Coordinator: Kara

Please review the entire packet and complete the enclosed forms. Remember to bring your current insurance card, a form of payment, and an up to date list of medications and supplements.

If you have questions regarding your appointment or this packet, please contact us at 541-687-8581. We invite you to visit our website at www.valleymedpc.com, where you can find more information about our providers and services.

We look forward to meeting you at your upcoming appointment scheduled on:

_____

Clinic hours are from 8:30 am -5:00 pm

If you are having a life-threatening emergency, please call 911. If you are experiencing a non-life-threatening medical issue and need to contact the clinic after hours please call the office number at 541-687-8581 and our answering service will connect you to the on-call physician.

Please contact your pharmacy for all prescription refills that do not have to be picked up in the office. If your Rx bottle indicates you are out of refills the pharmacy will send us the request to authorize additional refills. Please allow 48-72 business hours for your refill to be processed. If you are due for a follow up appointment please call the office to schedule.

It is necessary for our medical staff to prioritize call backs by addressing the most medically necessary calls first. We receive a lot of phone calls daily and try our best to answer them in a timely manner. The providers make most of their calls during lunch and after hours. Your call should be returned the day you call, however if you do not receive a call back in what you feel is a reasonable amount of time, please call again. Please remember the patient portal is for non-urgent communication only and a response should be returned within 48 hours.

We use an automated system to remind you of your appointments, and to inform you when a prescription has been sent to the pharmacy. A voice message will be sent as well as a text message reminder. If you answer your phone you can confirm your appointment by staying on the line. If you need to reschedule we ask you call the office, and we would be happy to assist you.

Onsite or telephonic interpretation services are available upon request.

Under law patients who don't have insurance or who are not using insurance have the right to receive a "Good Faith Estimate" explaining how much their care will cost. You have rights to dispute the charge if the bill is significantly more. Visit cms.gov/no surprises for more information.

We encourage you to visit our website at www.valleymedpc.com for more details regarding our office policies.

VALLEY MED'S NOTICE OF PRIVACY PRACTICES

Effective Date 1-1-2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer at 541-687-8581 or in writing at 10 Coburg Rd, Suite 201, Eugene, OR 97401

WHO WILL FOLLOW THIS NOTICE?

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Valley Med. Your health information may include information created and received by our office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our organization may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

  For payment. We may use and disclose health information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party.

  For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run our office and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Privacy Officer in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our Privacy Officer.
  You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by our office.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to our Privacy Officer.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be (*number*) of pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

  To obtain this list, you must submit your request **in writing** to our Privacy Officer. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to our Privacy Officer.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy on our website.

CHANGES TO THIS NOTICE
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

We will inform you of any significant changes to this Notice. This may be through a newsletter, a sign prominently posted at our office, a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION
We will inform you if there is a breach of your unsecured health information.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer listed on the first page. ***You will not be penalized for filing a complaint.***

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Date: _____/_____/_____ Primary Care Provider: _____

Patient Name _____
First Last Middle Initial

DOB____/____/____ **Sex:** Male □ Female □ Transgender □ **Social Security#:**_____-_____-_____

Mailing Address: _____

City:_____ **State:**_____ **Zip:**_____

Address (if different from mailing address) _____

Home Phone (land line only): (_____)_____ Ok to leave message? □

Cell Phone: (_____)_____ Ok to leave message? □

Employer:_____ **Work Phone** _____

Marital Status: Single Married Divorced Widow Partner

Emergency Contact: _____ _____ (____)_____
Name Relationship Phone Number

Email Address:_____

Are you web enabled for Valley Med's secure patient portal? Yes □ No □
If you are not web enabled and would like to be, provide us with your email, check the box and we will email you a user name and temporary password. The patient portal allows you to view your health information safely and securely in your own home. **Yes, I would like to be web enabled □**

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

Ethnicity: *(*please select one only*) Non-Hispanic or Latino Hispanic or Latino Unreported

Primary Language: _____ **Interpreter required? Yes □ No □**

Preferred Pharmacy/Location: _____

Mail Order:_____

Other than yourself, do you wish to give consent to share medical information with an individual(s)? If naming a person below, please be aware it is the sole responsibility of the patient or guardian (if a minor) to inform Valley Med if you wish to remove or change this consent in any way.

Name: _____

Automated appointment reminders/pharmacy notification options:

Preferred Phone number: Home (land line only) □ Cell □

Preferred Language: English □ Spanish □ **Preferred Time to Call**: Morning □ Afternoon □ Evening □

Insurance Information: *If the policy holder is someone other than the patient, please provide the following information* ***about them*** *in addition to a copy of the insurance card. See below if double covered.*

Primary Insurance - Co-pay $_____

Plan Name:_____

Policy Holder's Information/Main Subscriber:

Name:_____

DOB: ____/____/____ S.S.# _____-_____-_____

Phone _____

Relationship to patient: _____

Secondary Insurance- Co-pay $_____

Plan Name:_____

Policy Holder's Information/Main Subscriber:

Name:_____

DOB: ____/____/____ S.S.# _____-_____-_____

Phone _____

Relationship to patient: _____

***For those with more than one insurance plan**

It is important to "Coordinate Benefits" and ensure all plans are informed of one another. To avoid billing issues our billing office must know the correct order to submit your medical bills. Please review the general guidelines for double coverage.

- **Employee**- If you are employed, your employer sponsored plan is primary. Additional coverage through a spouse or parent would be secondary.
- **Dependent Child Covered Under More Than One Plan**- *The birthday rule* says that primary coverage comes from the plan of the parent whose birthday (month and day only) comes first in the year.
  Longer/Shorter Length of Coverage- If the previous rule doesn't apply, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
- **Medicaid-** A state sponsored plan is secondary to another insurance plan.

Responsible Party Information ****If patient is under 18 or a Dependant. ****

STATEMENTS WILL BE ADDRESSED TO RESPONSIBLE PARTY

Name_____ Relationship to Patient _____

Mailing Address_____ City_____ State_____ Zip_____

DOB_____/_____/_____ S.S.#_____-_____-_____ Employer_____

I authorize the providers in the above-named clinic to treat the person whose name appears in the patient information section.

_____ _____

****Patient Signature/Guardian Party's Signature*** Date

I hereby authorize the above-named clinic to furnish the insured's insurance company all information it may request concerning my medical care. I hereby assign to the provider(s) all money to which I am entitled for expense(s) relative to the services performed from time to time, but not to exceed my indebtedness to said provider(s). I understand I am financially responsible to said provider(s) for charges not covered by this agreement.

_____ _____

****Patient Signature/Guardian Party's Signature*** Date

I have been offered Valley Med's privacy policy statement? ***Received*** ***Declined***

_____ _____

****Patient Signature/Guardian Party's Signature*** Date

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Financial Policy Acknowledgement

In the interest of a good health care practice, it is desirable to establish an office and credit policy to avoid misunderstandings. Our primary responsibility is to help our patients enjoy a positive experience and provide excellent health care.

- Patients will need to provide our office with their social security number and health insurance card (if applicable) unless the total charge is paid in cash at time of service. Treatment may be postponed if patient does not furnish the items above.
- All accounts balances are due at the time of the visit (this includes co-pay, deductible, or percentage not paid by insurance). There will be a fee of $10.00 for those who are unable to pay their co-pay at the time of service.
- A 20% discount is extended to patients with no insurance coverage, but only applies when the visit is paid in full on the same day of the service.
- Insurance is billed as a courtesy to our patients. It is the responsibility of the patient to verify demographic and insurance information at every visit, and to inform the clinic of any changes. Any questions or disputes about the insurance policy, for example what treatment is covered and the patients out of pocket expense, will need to be resolved by the patient directly with their insurance carrier. Ultimately, the patient is responsible for the timely payment of their account.
- A fee of $15.00 will be charged if payment is not made by the due date listed on patient statement. There will be a charge of $25.00 for any NSF returned check.
- There will be a $100.00 charge for a missed appointment or canceling with less than 24 hours notice. Multiple missed appointments may result in scheduling limitations (scheduling the day you wish to be seen only) or discharge from the practice. The initial consultation appointment missed or NOT canceled with **24 hour** notice may result in the inability to reschedule or establish care at our facility. Appointment reminders are sent as a courtesy; however, it is the sole responsibility of the patient to be aware of their appointment date and time.

I have read Valley Med's credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a collection agency and I may be charged a collection fee of up to $75.00. Also, if it becomes necessary to effect collections on any amount owed on this or subsequent visits; the undersigned agrees to pay for all costs and expenses, including attorney fees.

Print Patient Name Date

Responsible Party Signature

valley MED @ the ten

Name _____ Date of birth _____

Comprehensive Adult New Patient Health History Questionnaire

If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it.

Who referred you to the practice?

Circle one: patient, family member, physician, assigned. Name? _____

Main reason for today's visit: _____

Other concerns: _____

_____

What are your health goals for the next year? _____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers & their specialty you see regularly: _____

_____

List any medical suppliers you use (e.g. respiratory supplies, etc): _____

MEDICATIONS: Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

Medication	Dose (e.g. mg/pill)	How many times per day?

ALLERGIES or intolerance to medications? □ **NONE**

(If yes, to what & what reaction?) _____

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____ Pneumovax (pneumonia) _____

Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date _____ Result, if known _____

Cologuard or Colonoscopy (circle one) Date (year)_____ Abnormal? □ No □ Yes

Polyp? □ No □ Yes

Women only:

Mammogram Most recent date/where _____ Abnormal? □ No □ Yes

Pap Smear Most recent date/where _____ Abnormal? □ No □ Yes

Bone Density Test Most recent date/where _____ Abnormal? □ No □ Yes

PERSONAL MEDICAL HISTORY:

Condition	*Now*	*Past*	*Comments*

□ **Check box if you have no history of significant medical illnesses.**

SURGICAL & PROCEDURE HISTORY – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	*Year*	*Comments*

□ **Check box if you have never had any medical procedures or surgeries.**

FAMILY HISTORY

Adopted? □ No □ Yes. If adopted and you do <u>not</u> know your family history skip the Family History section and continue to Health Issues on the next page.

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	*Father*	** Sister(s)*	** Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	
Alive									
Deceased									
Age currently or at death									

Diseases & Conditions	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	*Other blood relatives (list relationship to you)*	*List age(s) at diagnosis if known and if this was the cause of death*
No significant history known										
Hypertension – high blood pressure										
Kidney Disorder										
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes										
Cancer,/Type										
Stroke										

HEALTH ISSUES:

Tobacco Use:

Smoke or smoked cigarettes/ pipe/ cigars (circle)? □ Never □ Yes

Exposure to second hand smoke? □ No □ Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: _____ # of years: _____

Former smoker: Quit date: _____

Approximately how many packs/day did you smoke? _____

How many years did you smoke? _____

Other tobacco? (circle) Snuff or Chew

Quit date _____ Currently use? □ Yes

Are you ready to quit? □ No □ Yes

Alcohol Use:

Do you drink alcohol? □ No □ Yes

# of drinks/week: _____ □ Beer □ Wine □ Liquor

How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day? _____

Drug Use:

Have you **ever** used recreational drugs? □ No □ Yes

If yes, which ones? _____

Quit which ones? □ All _____

Any used currently? _____

Sexual Activity:

Are you sexually involved: □ Not currently □ Never □ Yes

Sexual partner(s) is/are/have been/may be in future: □ male □ female

Birth control method or STD prevention (check all that apply):

□ None needed □ Condom □ Pill □ IUD □ Patch □ Ring

□ Diaphragm □ Vasectomy □ Tubal ligation

□ Other method

(specify):_____

Diet:

Do you follow a special diet? □ No □ Yes

vegetarian, vegan, gluten free, other _____

Mood

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

SOCIAL DOCUMENTATION:

Name you prefer we use when contacting you (nickname, first, or last with Mr, Mrs, Ms, etc): _____

Country of birth: _____

Who lives at home with you: □ No one □ Spouse/partner □ Children _____

□ Pets (what type) _____ □ Other (roommates, extended family, etc) _____

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months:

SOCIOECONOMIC:

Occupation (or prior occupation): _____ Employer: _____

If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence □ disabled □ homemaker

□ other _____

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: _____

Number of children: _____ Ages (if minors): _____ # of grandchildren: _____ # of great grandchildren: _____

Education: □ high school or GED □ trade school □ college □ graduate school □ other _____

MEDICAL FORMS:

Please check any of the following forms you have completed:

- □ Advance Directive for Health Care (ADHC)
- □ Durable Power of Attorney (DPA) for healthcare decisions
- □ Living Will
- □ POLST (Physician Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____ Number of abortions: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause/hysterectomy): _____ □ Not applicable

Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every _____ days. How long do they last? _____ days.

Thank-you for taking the time to complete this form!