NEW PATIENT REGISTRATION PACKET

John M. Ray Jr., M.D.
Melissa Cupid, M.D.

Pinnacle Family Care, PLLC
3625 Cape Center Drive
Fayetteville, NC 28304

Dorothy Barbara, Practice Manager

Phone: 910-483-6114
Fax: 910-483-6225
www.pinnaclefamilycare.com

We are dedicated to providing quality medical care to our community by meeting the needs of each and every patient with respect and professional service.

Our goal is to provide a warm and compassionate environment that inspires mutual trust and confidence from our patient.

Please review and complete the following new patient application in its entirety and return it to our office via fax, mail, or in person. A representative will call to schedule your appointment within 24-48 hours.

Pinnnacle Family Care, PLLC
3625 Cape Center Drive
Fayetteville, NC 28304
Phone: 910-483-6114 Fax: 910-483-6225
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New Patient Registration Form

Patient Information

_______________ *(First, Middle, Last Name)* _______________ *(Date of Birth)*

_______________ *(Address)* _______________ *(City, State, Zip Code)*

_______________ *(Home Telephone Number)* _______________ *(Work Telephone Number)* _______________ *(Social Security Number)*

_______________ *(Email Address)* _______________ *(Prior Name)*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex: Male ☐ Female ☐ Ethnicity_______________ Race_______________

Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

_______________ *(Occupation)* _______________ *(Employer)*

_______________ *(Address)* _______________ *(City, State, Zip)*

Spouse Information

_______________ *(Name)* _______________ *(Date of Birth)*

_______________ *(Social Security Number)* _______________ *(Occupation)*

_______________ *(Employer)* _______________ *(Employer Phone Number)*

Relative to Contact in Case of Emergency

_______________ *(Name)* _______________ *(Phone Number)* _______________ *(Relationship to Patient)*

(Address) (City, State, Zip Code)

Primary Insurance Information

(Name of Insured) (Date of Birth) (Relationship to Patient)

(Insurance Company) (Group Number) (ID Number)

(Address) (City, State, Zip Code)

Secondary Insurance Information

(Name of Insured) (Date of Birth) (Relationship to Patient)

(Insurance Company) (Group Number) (ID Number)

(Address) (City, State, Zip Code)

Referred by:	Are your currently or have you recently seen other physicians or consultants? Reason for leaving?
☐ By a physician ☐ By a relative ☐ Advertisement/Yellow Pages ☐ By current patient	Name of provider and reason for leaving:

PFC cannot process third-party billing. Is your illness or injury related to any of the following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident	If Auto Accident, please print the state where the accident occurred below

Which pharmacy do you use? ______

Location: ______ **Phone:** ______

Responsible Person (If Applicable or If Patient is a Minor)

(Name) (Date of Birth) (Relationship to Patient)

(Address) (City, State, Zip Code)

(Phone Number) (Social Security Number) (Occupation)

(Employer) (Employer Phone Number)

Pinnacle Family Care, PLLC
3625 Cape Center Drive
Fayetteville, NC 28304
Phone: 910-483-6114 Fax: 910-483-6225

Agreement to Binding Arbitration

In accordance with the terms of North Carolina Uniform Arbitration Act (Revised), I agree to any dispute arising out of or related to the provision of health services to me or to my child by John M. Ray Jr., MD, including his/her/its employees, provider members, and agents, shall be resolved exclusively by final and binding arbitration, under the provisions of North Carolina Uniform Arbitration Act (Revised). I understand that this Agreement includes all healthcare services which previously have been or will in the future be provided to my child or to me, and that this Agreement is not restricted to those health care services rendered in connection with any particular treatment, office visit, or hospital admission. I agree that any arbitration award rendered shall be kept confidential by me and by my agents, and that any arbitration fees required to be paid shall be split equally between the parties. I understand that this Agreement is voluntary on my part and will in no way interfere with, no impact, medical services rendered or available to me. I further understand and acknowledge that the use of binding arbitration as an alternative resolution format benefits me and/or my doctor and his/her group. I understand that this Agreement is also binding on any individual or entity claiming by or through me or on my behalf. This document contains the entire agreement of the parties.

I acknowledge that I have had an opportunity to read this agreement, to ask questions about it, and that I understand it.

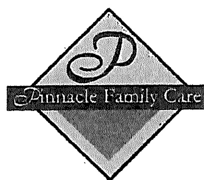
____
Signature Name of Patient and/or Guardian Date

____
Printed Name of Patient and/or Guardian

Witnessed By:

____
Signature of Medical Provider, Pinnacle Family Care, PLLC
John M. Ray, Jr., MD or Melissa J. Cupid, MD

*NOTE: If the individual signing this Agreement is doing so on behalf of his or her minor child, or any other person for whom he or she is legally responsible, then the signature above affirms that he or she has the authority or obligation to contract for the provision of health care services for that minor child or other person, and that his or her execution of this Agreement is in furtherance of that authority or obligation.



Pinnacle Family Care Financial/Billing Policy

In this agreement the words "you", "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payment(s) are credited. The words "we," "us", and "our" refer to Pinnacle Family Care, PLLC.

By executing and signing this agreement, you are agreeing to pay for all services that are rendered to you and/or those for whom you are the guarantor via your benefits plan or through direct payment on your behalf to Pinnacle Family Care.

Required Payments: *Any co-payments, co-insurance, and/or deductibles are due in full at the time of service. Please note that if you are unable to make your co-payment, deductible, or co-insurance, your insurance carrier may not cover your claim and the unpaid portion of your bill will become patient responsibility, or your appointment will be rescheduled. Because this is an insurance requirement, we cannot bill you for any of the above. For your convenience, we accept VISA, MasterCard, debit, cash, check, and/or money order as forms of payment.*

Monthly Statement: If you have a balance on your account, a monthly statement will be sent to you showing the charges on your account and any payment or credits applied to your account. This is your formal notification of any balance that is owed for services rendered.

Insurance Coverage/Cards: It is the responsibility of the patient to notify us of any changes in your insurance coverage. Please provide us with all insurance cards to copy at the time or your visit or at any time there is a change in coverage for you. Pinnacle Family Care cannot be held liable for the misfiling of claims if we do not have your updated information. Pinnacle Family Care is unable to file tertiary insurance at this time.

Due to timely filing regulations, claims will not be refiled with your new or additional insurance carrier if you did not present the insurance card to Pinnacle Family Care, PLLC at the time of service. The patient will be responsible for all balances remaining after insurance payment has been made by your insurance carrier as provided to us on that date of service.

Insurance: As a courtesy to our patients, we will be happy to accept assignment of benefits for most insurance companies. However, please be reminded that insurance is a contract between you and your insurance company. Pinnacle Family Care is not a party to this contract. The patient is fully responsible for all amount(s) not paid or covered by the insurance carrier.

Insurance Disputes: Pinnacle Family Care will not go into dispute with any insurance company with regard to insurance claims regarding any terms of coverage or lack thereof for services rendered. Although the actual dispute process is the patient's responsibility, Pinnacle Family Care will be more than happy to provide any information requested by your insurance company.

Payments: Unless we approve other arrangements through our Payment Arrangement Plan Contract, the balance due on your monthly statement is due and payable when the statement is issued, and is past due if not paid within thirty days (30). All past due accounts are subject to outside collection at any time.

Demographics: It is the patient's responsibility to notify our office of a change demographic information for example: a change of address, telephone number or email address. As a courtesy we provide appointment reminders, but if we are unable to contact you by the information provided you are still responsible to make your appointment.

Missed Appointment/No Show Fee: We required advance notice of 24 hours for all appointments for services rendered by Pinnacle Family Care to include specialty service appointments. Appointments can be cancelled at the time of your automated appointment reminder made the evening before your appointment or after hours with our answering service. Otherwise, if after normal business hours, you may contact our after hours service at 910-483-6114, the day before your appointment to cancel. ***A $50.00 regular follow up and $75.00 for a physical/yearly exam will be accessed to your account for each "no show" appointment or $35.00 for appointments that are cancelled with less than 24-hour notice. This fee or fee(s) must be paid prior to additional appointments being made.***

Please note that reminder calls are made as a courtesy and are not required. It is the patient's responsibility to keep their appointments. Therefore, this fee will not be waived unless under extenuating circumstances.

If a patient misses or has late cancellations for three (3) scheduled appointment, their account will be suspended and the patient will be dismissed/discharged from Pinnacle Family Care, PLLC.

Past Due Accounts: All accounts are to be settled within 15 days of notice Please note that there is a 1.5% interest rate accessed to all past due accounts over 90 days. If your account becomes past due, we are more than willing to assist you in resolving your debt. Our staff will assist you in a payment plan that best suits your budget and will also enable you to satisfy your debt within a set amount of time. After all resources have been exhausted on the part of Pinnacle Family Care, all payment arrangements made according to the Payment Arrangement Plan Contracts that are not adhered to, will be turned over to an outside collection agency for resolution. **The patient is responsible for all fees associated with this referral to the outside collection, to include a $30.00 Outside Collection Fee assessed to your account at the time of collections referral. In addition, past due accounts that are turned over to collections, will result in the immediate discharge from Pinnacle Family Care.** All account reinstatements will be considered on a case by case basis and the total account payment in full must be made, to include all associated fees via cash, money order, or credit/debit transaction only.

Return Check/Charge Insufficient Funds: Any return check(s) and/or charge(s) against a patient account will result in a $35.00 Insufficient Funds Fee allocated to the patient account and reversal of the original payment. The total amount is due plus the associated fee is due within ten (10) business days of notice. If payment is not made accordingly, the patient's account will be processed in accordance with the Past Due Accounts policy forestated above. The amount of the returned check must be paid with cash, credit card, or money order only. This fee must be paid prior to additional appointments being made. In addition, future visits will require an alternative form of payment.

All outstanding accounts not paid within the time allotted for NSF Returns, will be discharged from Pinnacle Family Care, PLLC and turned over to an outside collections agency with all associated fees applied as indicated in the Past Due section of this financial policy.

Refunds: Overpayments on accounts will be first credited to any and all outstanding balances that remain unsatisfied. Otherwise, the overage will be applied as a credit to your account. You may use this credit for any services provided by our office.

After Hours Advice: The Pinnacle Family Care office hours are Monday-Thursday 8am-5pm and Friday 8a-1pm. Our office is also closed during the 12p-1p-lunch hour. Any calls made to our office after business hours will be forwarded to our Emergency Answering Service and a Registered Nurse will handle your call.

Medical Records: All Medical Record requests and fees are handled by our third party vendor, Healthport and are billed in accordance with NC Regulations.

ACKNOWLEDGEMENT

____

Signature of Patient (parent/guardian/responsible party if minor) (Signature) Date

____

Printed Name of Responsible Party SSN# (if other than patient)

Authorization To Release Personal Health Information to Pinnacle Family Care

Request Date: ______/______/______

Patient Name: ______________________________

Date of Birth:______/______/______

Social Security Number: ______-______-______

Pinnacle Family Care
3625 Cape Center Drive
Fayetteville, NC 28304
Phone: (910) 483-6114
Fax (910) 483-6225

ALL BLANKS MUST BE FILLED IN AND A COPY OF THE FORM GIVEN TO THE PATIENT
This authorization will expire automatically after 90 days from the date signed and unless permitted by law, further release of this information is prohibited without your prior written consent.

I am requesting that the medical facility listed below (sender), release copies of my medical records to Pinnacle Family Care, PLLC. Please note that Pinnacle Family Care is not responsible for any charges associated with this request.

Sender:

____

____

____

Send to: **Pinnacle Family Care, PLLC**
3625 Cape Center Drive
Fayetteville, NC 28304
Fax: (910) 483-6225

Purpose of Disclosure:____

Please include the following information:

☐Records for the last 3 years ☐Lab Reports ☐X-Ray Reports/Films

☐Other____

I DO ☐ **I DO NOT** ☐ authorize the release of parts of the record that relate to substance abuse, psychological/psychiatric conditions, and/or communicable diseases including AIDS or tests for infection with HIV, if present.

I understand fully understand that this authorization request is made voluntarily on my part and agree to pay for all fees associated with this request as listed below at the time of request:

____ Date
Signature of Patient or Legal Representative

____ Date
Signature of Witness(Pinnacle Family Care Staff)

PINNACLE FAMILY CARE, PLLC

Authorization for Disclosure of Health Information

Patient Name ____

Date of Birth ___/___/___ Phone Number __________________ History #__________________

I hereby give Pinnacle Family Care, PLLC my permission to release my medical information to the individuals specified below, upon their request. Methods of release may include verbal discussions or updates about my treatment, medications, or condition as requested. The purpose for these disclosures is to enable the persons below to assist me in maintaining my health, and to participate in my medical care.

Name: ____________________________ Relationship____________ DOB__________ TEL#__________________

Name: ____________________________ Relationship____________ DOB__________ TEL#__________________

Name: ____________________________ Relationship____________ DOB__________ TEL#__________________

The patient or the patient's representative must read and initial the following statements.

1. I understand that I may see and receive a copy of this form, if I request it, and that I may get a copy of this form after I sign it. *Initials:* __________
2. **The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse, infectious diseases including HIV, elective cosmetic procedures, medical correspondence and billing information. If you do not wish such information to be released, do not complete this form.** *Initials:* __________
3. I understand that I may revoke this authorization any time by notifying Pinnacle Family Care, PLLC in writing, but the revocation will not affect any actions which they have taken prior to the receipt of the revocation. Without express written revocation directed to Pinnacle Family Care, PLLC I understand that this authorization will not expire during the remainder of my treatment period with Pinnacle Family Care, PLLC and until such time as I present Pinnacle Family Care, PLLC with a revocation of authorization, or complete a new authorization form. *Initials:* __________
4. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand and acknowledge that the confidential healthcare disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization to receive the information and may no longer be protected by federal privacy regulations upon re-disclosure. *Initials:* __________

I authorize the information to be disclosed as specified below: (check and complete all that apply)

_____On my voicemail/answering machine at home ____________________________ (specify phone #)

_____On my voicemail/answering machine at work ____________________________ (specify phone #)

_____ On my voicemail on my cell ______________________________________ (specify phone #)

____ Date: ____________________________

Signature of patient or patient's legal representative Date

(Form MUST be completed before signing)

____

Printed name of patient's representative Relationship to patient

____ Relationship: ____________________________

Witness

This consent form will expire when revoked in writing by the patient/representative or in the case of a minor, on the date the minor becomes an adult under state law, whichever occurs first.

Pinnacle Family Care, PLLC

NOTICE OF PRIVACY PRACTICES
EFFECTIVE 9/1/2013 Revised

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. You have the right to a paper copy of this Notice; you may request a copy at any time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

We may use and disclose your health information for the following purposes without your express consent or authorization.

Treatment. We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to persons outside our organization involved in your treatment, such as other health care providers, family members, and friends.

We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying our organization and asking for you to return our call. We will not disclose any health information to any person other than you except to leave a message for you to return the call.

Payment. We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates. We provide some services through contracts or arrangements with business associates. We require our business associates to appropriately safeguard your information.

Creation of de-identified health information. We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and disclosures required by law. We will use and/or disclose your information when required by law to do so.

Disclosures for public health activities. We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures about victims of abuse, neglect, or domestic violence. We may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

Disclosures for law enforcement purposes. We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures regarding victims of a crime. In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Disclosures to avert a serious threat to health or safety. We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Pinnacle Family Care, PLLC

I, ____________________, have been made available a copy of Pinnacle Family Care's Notice of
Patient Name

Privacy Practices.

_________________________ ____________________

Signature of Patient Date

Pinnacle Family Care Standard Office and Hospital Procedures

Scheduling: Pinnacle Family Care patients may schedule appointments by calling (910) 483-6114 during our normal business hours. *All copays, deductibles, and/or coinsurance must be paid at the time of service. You will not be billed for any of the above. If you are unable to meet your copay, deductible, and/or coinsurance, your appointment will be rescheduled.*

When scheduling please be prepared to provide the following information:

- Full Name
- Date of Birth
- Verification of your address, phone number, and current insurance carrier(s)
- It is mandatory that you bring your current insurance card to every visit for verification.
- Reason for your appointment.
- Appointment reminders is a courtesy. If you do not receive a reminder call, text, or email you are still responsible to keep your appointment unless a cancellation call is received at least 24 hour in advance.
- All patients under the age of 18 years must be accompanied by an adult parent or guardian. The parent may send a verifiable note giving PFC permission to see the patient without the parent being present.

Please note that you are required to present your insurance card(s) at each visit and meet all copayment, deductible, and/or patient balance obligation(s) prior to being seen.

Please note: Once you have scheduled an appointment with Pinnacle Family Care, we require a 24-hour advance notice for all cancellations to avoid a $50.00 for a regular follow-up or $75.00 for a physical/yearly exam "no-show" or $35.00 late cancellation fee. This fee is due prior to any additional appointments being made. Any patient who misses or has late cancellations for three (3) scheduled appointments, will be dismissed/discharged from Pinnacle Family Care, PLLC.

Patient Messages: *All messages for the nursing staff or your provider will be answered within 24 hours from the time of your call. This timeframe does not include weekends.*

All prescription refill requests are satisfied <u>within 48 hours</u> after the request is made. (not including weekends) Please call a least one week prior to running out of your medications.

When calling in a refill request, please be prepared to provide the following information:

- Full Name and Date of Birth
- Name of the prescription(s), dosage, and quantity
- Name of your pharmacy or if you require a written prescription for pick up

After Hours Advice: All calls related to prescriptions, lab results, appointments, and or general medical advice, should be made during normal business. *The Pinnacle Family Care office hours are Monday-Thursday 8am-5pm and Friday 8a-1pm. Our office is also closed during the 12p-1p-lunch hour. Any calls made to our office after business hours will be forwarded to our Emergency Answering Service and a Registered Nurse will handle your call.*

Hospital guidelines: No lobby privileges will be given. No information regarding a patient's medical condition will be released to family members without a written consent signed by the patient or legal guardian. In the event that the patient is unable to communicate then the doctor will speak to a family spokesman.

Revised 6/3/2015

Pinnacle Family Care, PLLC
3625 Cape Center Drive
Fayetteville, NC 28304-4457
Phone 910-483-6114
Fax 910-483-6225

Original Date:	09/03/2003
Dates Revised:	01/02/2007
Date Revised:	03/12/2014

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

Sex			
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Question	Yes	No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Dominant Hand: ☐ Left ☐ Right

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	