

# HILLSBORO CLINIC

Excellence in Primary Care



356 SE 9<sup>th</sup> Ave  
Hillsboro, OR 97213  
www.HillsboroClinic.com  
503.681.4366 (phone)  
503.681.4374 (fax)

DR. MARC E. LEWIS   DR. MEENAKSHI AGGARWAL   ANNE DUNNE, FNP   MELINDA SANFILIPPO, FNP

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PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

Thank you for attending your annual health maintenance exam. Depending on your health insurance plan, you may receive preventative benefits for a reduced copay or no copay. We would like to clarify the services covered as preventative benefits and what can and cannot take place during your visit to avoid additional charges.

#### Covered:

- Age/Gender focused exam
- Advice for disease prevention and healthy living
- Discussions about previously identified risk factors (i.e. smoking)
- Lab/Imaging tests to screen for diseases for which you may be at risk due to age, gender, or lifestyle
- Standard age-based immunization

#### Non-Covered:

- New problems that require lab test, images or other evaluation
- New problems that require prescription medication
- Minor procedures (i.e. skin tag removal, wart treatment)
- Chronic problems that require evaluation, management strategies and possibly changes in medication
- Immunizations specific for traveling

You may schedule a separate appointment to address new problems or unstable chronic conditions. On the other hand, if you make an appointment for a health maintenance visit and have additional concerns, your provider may want to focus on your concerns first and defer the health maintenance visit until another appointment. Non-preventative issues could result in additional charges for the tests or office visit. In many cases, we provide more than the basic requirements in order to provide more complete care. Please note that this handout does not completely define our inclusions or exclusions.

*As a patient of the Hillsboro Clinic I understand that any and all charges associated with the cost of a routine Health Maintenance physical exam may not be covered by my health insurance carrier if I discuss any of the above mentioned Non-Covered services with my provider during the exam. I also understand that any and all diagnostic tests ordered by my provider and performed as a result of current health issues discussed during my exam may not be covered by my insurance. If my insurance does not cover these services I may be held financially responsible for the charges related to these services.*

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

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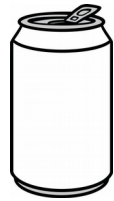
PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

## Annual Questionnaire

Once a year, all our patients are asked to complete this form because drug use, alcohol use, and mood can affect your health as well as medication you may take. Please help us provide you with the best medical care by answering the questions below.

Are you currently in recovery for alcohol or substance use?

- Yes       No



12 oz. Beer



5 oz. Wine



1.5 oz. Liquor

**ALCOHOL:** One Drink =

	None	1 or more
MEN: How many times in the past year have you have 5 or more drinks in a day?	<input type="radio"/>	<input type="radio"/>
WOMEN: How many times in the past year have you have 4 or more drinks in a day?	<input type="radio"/>	<input type="radio"/>

**DRUGS:** Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	<input type="radio"/>	<input type="radio"/>

## MOOD:

	None	1 or more
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	<input type="radio"/>	<input type="radio"/>
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	<input type="radio"/>	<input type="radio"/>

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## Patient Intake Form for Annual Physical

### Medication Allergies:

Please list any below.

In the past year have you been hospitalized, injured, or had surgery?

If so, what and when?

### Social History:

Marital status: \_\_\_\_\_

Job type: \_\_\_\_\_

Children: \_\_\_\_\_

Do you smoke?

If so, what, how much, and for how long?

Do you drink?

If so, what and how much per week?

Do you recreational drugs?

If so, what, how much per week, and for how long?

### Advance Directive

If you are over the age of 70, do you have a health care advance directive/living will, or health care proxy/power of attorney?

PATIENT: \_\_\_\_\_

DOB: \_\_\_\_\_

Review of Systems

Do you have any of the following problems and diseases?

Headaches	___ Yes	___ No	Alcoholism	___ Yes	___ No
Blurred vision	___ Yes	___ No	Arthritis	___ Yes	___ No
Chest pains	___ Yes	___ No	Cancers	___ Yes	___ No
Palpitations/racing heart	___ Yes	___ No	Diabetes	___ Yes	___ No
Lightheadedness	___ Yes	___ No	Dementia	___ Yes	___ No
Shortness of breath	___ Yes	___ No	Heart Disease	___ Yes	___ No
Swelling to legs/hands	___ Yes	___ No	Kidney Disease	___ Yes	___ No
Loss of energy	___ Yes	___ No	Liver Disease	___ Yes	___ No
Heartburn	___ Yes	___ No	Irregular Pulse	___ Yes	___ No
Nausea	___ Yes	___ No	Obesity	___ Yes	___ No
Diarrhea	___ Yes	___ No	Lung Disease	___ Yes	___ No
Blood in stools	___ Yes	___ No	Chronic Pain	___ Yes	___ No
Joint pain	___ Yes	___ No	Skin changes	___ Yes	___ No
Tremors	___ Yes	___ No	Seizures	___ Yes	___ No
Excessive sweating	___ Yes	___ No	Stroke	___ Yes	___ No
Incontinence (urine/stool)	___ Yes	___ No	Thyroid Disease	___ Yes	___ No

Hearing Loss Screen:

1. Do you have trouble hearing the television or radio when other don't? \_\_\_ Yes \_\_\_ No
2. Do you strain to hear/understand conversations? \_\_\_ Yes \_\_\_ No

Fall Prevention:

Do you fall frequently? \_\_\_ Yes \_\_\_ No

If so, does your home have

- |                                     |   |
|-------------------------------------|---|
| Rugs in the hallway? ___ Yes ___ No | Grab bars in the bathroom? ___ Yes ___ No |
| Poor lighting? ___ Yes ___ No       | Handrails on the stairs? ___ Yes ___ No   |

Exercise

How often do you exercise?

Daily: \_\_\_ 4-5 days per week: \_\_\_ 2-3 days per week \_\_\_ 1 day per week \_\_\_ None \_\_\_

Regimen?

Walking: \_\_\_ Run: \_\_\_ Bike: \_\_\_ Gym: \_\_\_ House/Yard work: \_\_\_ Other: \_\_\_

Dietary

Rate your healthy diet habits: Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_ None \_\_\_

Type: Low carb \_\_\_ Low salt \_\_\_ Low fat/cholesterol \_\_\_ Reduced portions \_\_\_

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

Sleep Health

Is your sleep sufficient?  Yes  No      Hour per night \_\_\_\_\_  
Naps?  Yes  No      Occasional  Regular   
Snoring?  Yes  None reported  
Apnea?  Yes  None reported  
Daytime sleepiness?  Yes  No  
Medications tried?  Yes  No  
Medication Name(s):  
  
Effective?  Yes  No      Partial   
Details:

Bladder Control Issues

1. Do you have trouble with urinary leakage?  Yes  No
2. Would you like to discuss treatment options?  Yes  No

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## Patient Health Questionnaire (PHQ-9)

Date: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
 (Please clearly circle your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

TOTAL:

10. If you have circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____
	Somewhat difficult _____
	Very difficult _____
	Extremely difficult _____

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## Family History

Disorder	Father	Mother	Brother	Sister	Son	Daughter	Other
Alcoholism							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cervical Cancer							
Colon Cancer							
Congestive Heart Failure							
Coronary Heart Disease							
Depression							
Diabetes							
Hypertension							
High Cholesterol							
Kidney/Renal Disease							
Lung/Respiratory Disease							
Migraines							
Osteoporosis							
Seizures							
Severe Allergies							
Stroke/CVA							
Thyroid Disorder							
Melanoma							
Obesity							
Other Cancer							
Ovarian Cancer							
Uterine Cancer							

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## Chart Update

Contact Information:      Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_      Cell (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

1. Do you suffer from allergy symptoms?    Yes \_\_\_\_\_ No \_\_\_\_\_

2. Is your quality of life affected by your allergy symptoms?

Yes \_\_\_\_\_ No \_\_\_\_\_ Mildly \_\_\_\_\_ Moderately \_\_\_\_\_ Considerably \_\_\_\_\_

3. Are you currently or have you in the last 12 months taken any prescription or over-the-counter antihistamine medications to alleviate your allergy symptoms?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list the medications: \_\_\_\_\_

4. Are you currently or have you in the last 12 months taken any prescription or over-the-counter steroidal medications to alleviate your nasal symptoms or hay fever?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list the medications: \_\_\_\_\_

5. Are you currently or have you in the last 12 months taken any prescription or over-the-counter inhaled medications to alleviate asthma symptoms?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list the medications: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_