HILLSBORO CLINIC
Excellence in Primary Care

356 SE 9th Ave
Hillsboro, OR 97123
www.HillsboroClinic.com
503.681.4366 (phone)
503.681.4374 (fax)

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

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 <u>not</u> 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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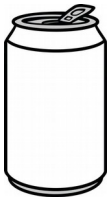
PATIENT: _____ DOB: _____

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

ALCOHOL: One Drink =  12 oz. Beer  5 oz. Wine  1.5 oz. Liquor

	None	1 or more
MEN: How many times in the past year have you have 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you have 4 or more drinks in a day?	○	○

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?	○	○

MOOD:	None	1 or more
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

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PATIENT: _____ DOB: _____

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:

Martial 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: _____ DOB: _____

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							