

# HILLSBORO CLINIC

Excellence in Primary Care



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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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Social Questionnaires: Circle or write your answers.

Marital Status: Single Married Separated Divorced Widowed Other \_\_\_\_\_

How many children do you have? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Who do you currently reside with? \_\_\_\_\_

### Advance Care Planning:

Do you have a medical power of attorney? YES NO  
Do you have an Advance Directive? YES NO

### Exercise:

What is your exercise level? None Occasional Moderate Heavy  
How many times per week do you exercise? Less than 1 time per week  
1-2 times per week 3-4 times per week 5-7 times per week

### Diet:

Rate your healthy diet habits. Excellent Good Fair Poor None  
What type of diet are you following? Regular Vegetarian Vegan Gluten Free  
Carbohydrates Cardiac Diabetic

Do you or have you ever smoked tobacco? YES NO  
Do you or have you ever used any other form of tobacco or nicotine?  
At what age did you start smoking tobacco?  
When did you quit smoking?

### Hearing Screen:

Do you have trouble hearing the television or radio when others don't? YES NO  
Do you strain to hear/understand conversations? YES NO

### Bladder Control Screen:

Do you have trouble with urinary leakage? YES NO  
If yes, would you like to discuss options? YES NO

### Sleep Health:

Is your sleep sufficient? YES NO How many hours per night do you sleep? \_\_\_\_\_  
Do you take naps? YES NO How often? Regularly Occasionally No naps  
Do you snore? YES NO Do you have sleep apnea? YES NO  
Do you experience daytime sleepiness? YES NO  
Have you tried any medications for sleeping? YES NO  
Were the medications you tried helpful? YES NO N/A

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Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Family History: Please identify conditions that apply to those of family members listed. Please identify if it is Paternal or Maternal Grandparent.

Disorder:	Father	Mother	Brother	Sister	Son	Daughter	Grandmother (P/M)	Grandfather (P/M)
Alcohol Abuse								
Alzheimer's								
Anemia								
Arthritis								
Asthma								
Blood Coagulation disorder								
Cerebrovascular incident								
Dementia								
Depressive disorder								
Diabetes								
Disease of liver								
Disorder of thyroid								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Uterine Cancer								
Breast Cancer								
Cervical Cancer								
Colon Cancer								
Ovarian Cancer								
Migraine								
Osteoporosis								
Seizure Disorder								

Please provide any other specialist that you actively receive care from and what type of care that you receive.

Name and Specialty/Provider Type:

Type Of Care:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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PERSONAL MEDICAL HISTORY: CIRCLE ANY CONDITIONS FOR WHICH YOU HAVE.

ADD/ADHD	Alcoholism	Allergies/Hayfever	Anemia
Anxiety Disorder	Arthritis	Asthma	Birth Defects/Inherited
Blood diseases	Breast Cancer	Cancer: _____	Colon Cancer
Congestive Heart Failure	Dementia/Alzheimer's	Depression	Development/Behavioral Disorder
Diabetes: Type _____	Eczema (Chronic Rash)	Headaches (Migraines)	Heart Disease (Valve)
Heart Disease (Attack)	Heart Rhythm Problems	High Cholesterol	High Blood Pressure
High Thyroid Levels	Low Thyroid Levels	Infertility	Kidney Disease
Obesity	Osteoporosis	Ovarian Cancer	Polyps (colon)
Seizures/Epilepsy	Skin Cancer	Stroke	Thrombophilias (bleeding disorder)

Please list if you have any new allergies:

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Please list if you have been prescribed any new medications from any outside providers?

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# Patient Health Questionnaire

Date \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Over the last 2 weeks, how often have you been bothered by any of the following problems?  
Please circle your answers.**

PHQ-9	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 in some way.	0	1	2	3
<b>Add the score for each column</b>				

**Total Score (add your column scores):** \_\_\_\_\_

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all
Somewhat difficult
Very Difficult
Extremely Difficult

**Over the last 2 weeks, how often have you been bothered by any of the following problems?  
Please circle your answers.**

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
<b>Add the score for each column</b>				

**Total Score (add your column scores):** \_\_\_\_\_

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all
Somewhat difficult
Very Difficult
Extremely Difficult

## Substance Screening

Circle your answers

How often did you have a drink containing alcohol in the past year?

Never                                      Monthly or less                                      2-4 times a month  
2-3 times a week                                      4 or more times a week

How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

0      1 or 2      3 or 4      5 or 6      7 to 9      10 or more

How often did you have 6 or more drinks on one occasion in the past year?

never                      less than monthly                      monthly                      weekly  
daily or almost daily

### Steady Falls Risk (circle your answer)

Have you fallen in the past year?	YES	NO
Do you use or have you been advised to use a cane or walker?	YES	NO
Do you sometimes feel unsteady while walking?	YES	NO
Do you feel steady yourself by holding onto furniture when walking at home?	YES	NO
Do you worry about falling?	YES	NO
Do you need to push with your hands to stand up from a chair?	YES	NO
Do you have trouble stepping up onto a curb?	YES	NO
Do you often have to rush to the toilet?	YES	NO
Have you lost some feeling in your feet?	YES	NO
Do you take medicine that sometimes makes you light headed or more tired than usual?	YES	NO
Do you take medicine to help you sleep or improve your mood?	YES	NO
Do you often feel sad or depressed?	YES	NO