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 reviece preventative benefits for a reduced or no co-pay. We would like to clarify the services covered as preventative benenfits 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 test to screen for diseases for which you may be at risk due to age, gender, or lifestyle
    - Labs are LIMITED to screening conditions not already diagnosed.
- Standard age-based immunization

Non-Covered:

- New problems that require prescription medication
- New problems that require lab test, images or other evaluation
    - This includes lab to check on status of current conditions
- Minor Procedures (i.e. skin tag removal, wart treatment)
- Chronic problems that require management strategies and changes to plan of care
- 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 visits until another appointment. Non-preventative issues could result in additional charges for the test 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 and exclusions.

As a patient of the Hillsboro Clinic I understand that any and all charges associated with the cost of a s routine Health Maintenance physical exam may not be covered by my health insurance carrier if I discuss any of the above mentioned Non-coveredservices 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 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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Name: _____
Date of Birth:_____

Social Questionaires: 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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Name: _____
Date of Birth:_____

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:

_____

_____

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

_____

_____

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
Add the score for each column				

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
Add the score for each column				

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**

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Substance Screening

Name: _____

Date of Birth:_____

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

Steadi 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