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.)	**DOB:**
Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed	
Previous or Referring Provider:	Date of last physical exam:

List your Prescribed Drugs and Over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
List any medical problems that other doctors have diagnosed		
Allergies to Medications		
Name the drug	Reaction You Had	

Surgeries		
Year	Reason	Hospital
Other Hospitalizations		
Year	Reason	Hospital

Have You ever had a blood Transfusion?	□Yes	□No

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2564 NE Courtney Dr.
Bend OR 97701

FAMILY HEALTH HISTORY		
	Age	**Significant Health Problem**
Father		
Mother		
Siblings	□ M □ F	
	□ M □ F	
	□ M □ F	
Children	□ M □ F	
	□ M □ F	
	□ M □ F	
Grandmother *Maternal*		
Grandfather *Maternal*		
Grandmother *Paternal*		
Grandfather *Paternal*		

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 min.)					
Diet	Are you dieting?			□ Yes		□ No
	If Yes are you on a physician prescribed diet?			□ Yes		□ No
	# Of meals you eat in a day?					
	Rank salt intake	□High	□Medium	□Low		
	Rank Fat intake	□High	□Medium	□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 you drink?				□ Yes	□ No
Tobacco	Do you use tobacco?				□ Yes	□ No
	□ Cigarettes- #/Day	□ Chew-#/day	□ Pipe-#/day	□ Cigars-#/day		
	# of years		Or Year quit			
Drugs	Do you currently use recreation street drugs?				□ Yes	□ No
	Have you ever given yourself street drugs with a needle?				□ Yes	□ No

Sex	Are you sexually active?	□ Yes	□ No
	If yes, are you trying for a pregnancy?	□ Yes	□ No
	If not 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 and/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

REVIEW OF SYSTEMS

Please circle anything that applies.

Constitutional	Allergy	Eyes	Ear/Nose/Throat	Endocrine
Change in appetite	Blistering of skin	Squinting	Frequent Runny Nose	Cold Intolerance
Chills	Congestion	Crossed Eyes	Unusually Loud Voice	Difficulty Sleeping
Fatigue	Cough	Asymmetric Gaze	Mouth Breathing	Dizziness
Fever	Hives	Blurred Vision	Bad Breath	Excessive Sweating
Headaches	Itching	Diminished Visual Activity	Problem with gums/teeth	Excessive Thirst
Light Headedness	Rash	Discharge	Tugging at ears	Frequent Urination
Night Sweats	Sneezing	Flashes of Light	Blocked Ear	Heat Intolerance
Sleep Disturbance	Watery Eyes	Floaters In Visual Field	Decreased Hearing	Irregular Periods
Weight Gain	Wheezing	Itching and Redness	Decreased Sense of Smell	Weakness
Weight Loss	Hay Fever	Pain	Difficulty Swallowing	Weight Loss
		Red Eye	Dry Mouth	
		Vision Screen	Ear Pain	
			Hearing Screen	
			Nose Bleeds	
			Ringing in ear	
			Sinus Pain	
			Sore Throat	
			Swollen Glands	

Respiratory	Breast	Cardiovascular	Gastrointestinal	Hematology
Change In breathing	Blood Nipple	Tire Easily	Abnormal Pain	Breast Lump
Chest Pain	Breast Lump	Fainting	Blood In Stool	Dizziness
Cough	Breast pain	Chest pain at Rest	Change In Bowel	Fever
Pain When Breathing	Breast Swelling	Chest Pain w/ Exertion	Constipation	Groin Mass
Shortness of Breath	Fever	Limping	Decreased Appetite	Prolonged Bleeding

Respiratory	Breast	Cardiovascular	Gastrointestinal	Hematology
Shortness w/ exertion	Gland Swelling	Cyanosis	Diarrhea	Recent Transfusion
Sputum Production	Nipple Discharge	Difficulty Lying Flat	Difficulty Swallowing	Swollen Glands
Wheezing	Red Skin	Dizziness	Exposure to Hepatitis	Weakness
	Weight Loss	Shortness Of Breath	Heartburn	Weight Loss
		Fluid in Legs	Hematemesis	
		Irregular Heart Beat	Nausea	
		Weight Gain	Rectal Bleeding	

Women Only	Men Only
Dysuria	Erectile Dysfunction
Breast Lump	Testicular Mass
Breast Pain	Dysuria
Discharge From Breast	Difficulty Initiating Stream
Heavy Bleeding During Periods	Dribbling after Urination
Hot Flashes	Hard Testicle
Irregular Menstruation	Hernia
Missing Menstruation	Blood When Urinating
Painful Intercourse	Lump In Groin
Painful Menstruation	Penile Discharge
Vaginal Bleeding between Menstruation	Rash or Blisters On Penis
Vaginal Discharge/ Itching	Scrotal Swelling
	Not Descended Testicle

Genitourinary	Musculoskeletal	Skin	Neurologic	Psychiatric
Bedwetting	Muscle Pain	Acne	Weakness	Bad Temper
Discharge	Decreased Movement	Blistering of Skin	Clumsiness	Nail Biting
Abdominal Pain	Carpal Tunnel	Discoloration	Balance Difficulty	Anxiety
Blood In Urine	Joint Stiffness	Dry Skin	Change In coordination	Hallucinations
Difficulty Urinating	Leg Cramps	Eczema	Difficulty Speaking	Delusions
Frequent Urination	Muscle Aches	Hives	Dizziness	Depressed Mood
Pain in Lower Back	Pain in Shoulders	Itching	Fainting	Difficulty Sleeping
Painful Urination	Painful Joints	Keloid Formation	Gait Abnormality	Eating Disorder
	Sciatica	Moles	Headache	Loss of Appetite
	Swollen Joints	Nodules	Irritability	Abuse
	Trauma To Arms	Photosensitivity	Loss Of Strength	Stressor
	Trauma To Knees	Rash	Unable to Use Extremity	Substance Abuse
	Trauma To Ankles	Rash On Feet	Low Back Pain	Suicidal Thoughts
	Weakness	Scaly lesion	Memory Loss	
		Skin Cancer	Pain	
		Skin Lesion	Seizures	
		Skin Oozing	Tics	
		Sun Sensitivity	Tingling/ Numbness	
			Loss Of Vision	
			Tremor	

Weeks Family Medicine

If you are new to Weeks Family Medicine, we welcome you and express our appreciation that you have chosen our office to provide your primary care needs. If you are an established patient, we thank you for continuing to allow us to provide your primary healthcare.

Cancellation of Appointments

_____ (***Initials)*** We ask that you provide *at least* 24 hours advance notice to cancel an appointment. If, however, due to circumstances not under your control, you are unable to keep your appointment and are also unable to provide at least 24 hours advance notice, please let us know as soon as possible so that we may schedule another person requiring care. Please be advised, we reserve the right to terminate our relationship with you as our patient if this occurs on three occasions.

Referrals for Specialty Care

_____ (***Initials)*** If your insurance company requires that you obtain a referral from a primary care provider prior to seeing a specialist, they also require your primary care provider to conduct a medical evaluation of your medical problem and your need for specialty care. Therefore, if you believe you need to see a specialist, we ask that you make an appointment with your primary care provider so that he/she may evaluate the problem and make a determination of the need for, and nature of, the specialty referral. If you are currently being seen by a specialist and need your referral renewed, we ask that you notify us of your need for a new referral at least one week in advance of your appointment with the specialist to allow us the time to prepare the referral.

Prescription Refills

_____ (***Initials)*** Please call your pharmacy regarding refills on medication *at least* 48 hours in advance to allow sufficient time for the pharmacy, and for your provider, to receive and respond to your request before you run out of your medication. For maintenance medication, your provider will normally provide refills to last until it is time for your next office visit. If you are out of refills, this may indicate that it is time for you to schedule an appointment with the provider.

Narcotic Prescription Policy

_____ (***Initials)*** Lost, stolen or damaged narcotic/controlled substance prescriptions will NOT be replaced. Therefore, prior arrangements need to be made to pick up these prescriptions to accommodate these hours. We will provide you with our narcotic/controlled substance policy which outlines all these details.

Telephone Calls

_____ (***Initials)*** Should you have a brief question or feel the need to speak to your provider by phone, we are available to answer phone messages during those clinic hours when we are not actively providing direct patient care. This is usually at the end of the day. The medical assistant may be asked to return your call after discussing the matter with the provider. Considerable effort is made to respond to phone messages within 24 hours of their receipt, however, with a busy clinic schedule, our telephone time is limited. It is preferable that the evaluation and treatment of medical problems be conducted during a scheduled office visit with your provider where you can receive adequate care and attention. We appreciate your understanding and consideration in this regard.

Payment Agreement

_____ (***Initials)*** I understand that prompt payment for all services is my responsibility regardless of the insurance or third party coverage.

A monthly statement will be sent to you. We accept all forms of payment. Legal procedures for collection of past due accounts will be initiated if non-payment of account extends beyond 120 day, if no arrangements have been made otherwise. The undersigned will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action commences to collect past due accounts.

We are committed to providing the best possible care for you. Our fees fall within the acceptable range by most companies, and therefore are covered up to maximum allowance determined by each carrier. Not all services

are a covered benefit in all contracts. To help you receive the maximum benefit from your insurance, we need your assistance and your understanding of our payment policy.

We are happy to process insurance claims and request assignment of private benefits unless you pay in full at the time of treatment. **It is your responsibility to understand your insurance policy and coverage.** Should insurance payments issued to Weeks Family Medicine result in a credit balance on your account, a refund will be issued to you or your insurance company once course of treatment has all been reconciled.

I authorize payment of medical benefits to Weeks Family Medicine, and I have read and understand this payment agreement.

We thank you for allowing us to participate in your health care and hope the above information will assist you in obtaining prompt, convenient medical care.

Sincerely,
Weeks Family Medicine

Patient Signature ____ Date ______________________

Printed Name ____

REGISTRATION FORM

PATIENT INFORMATION					
Patients Last Name: First: Middle:			☐ Mr. ☐ Mrs.	☐ Miss. ☐ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former Name:	Birth Date: / /	Age:	Sex: ☐ M ☐ F
Street Address:	Social Security #	Phone Number:			
P.O. Box:	City:	State:	ZIP Code:		
Email:	Occupation:	Employer:	Employer Phone #		
Preferred Pharmacy:	Pharmacy Location:				

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ American Indian or Alaska Native	☐ Hispanic	☐ English
☐ Asian	☐ Non-Hispanic/Non-Latino	☐ Spanish
☐ Native Hawaiian, Pacific Islander	☐ Refused	☐ Other
☐ Black or African American		
☐ White or Caucasian		
☐ Other		
☐ Refused		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at the same address) :	Relationship to patient:	Home Phone No:	Work Phone #

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Weeks Family Medicine or insurance company to release any information required to process my claims.

X____ ____

Patient/Guardian signature Date

Authorization for Release of Information (HIPAA)

Patient Name ___________________________________ Date of Birth __________________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to anyone other than yourself, you must sign this form. Signing this form will only give information to those indicated below.

I authorize Weeks Family Medicine to release my medical and/or billing information to the following individual(s):

1.________________________________Relation:_____________________Phone:__________________

2.________________________________Relation:_____________________Phone:__________________

3.________________________________Relation:_____________________Phone:__________________

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: ____ Date: ________________________

Printed Name: ____