

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
	<input type="checkbox"/> Do you have any chest pain, dizziness, and palpitations during exercise or after exercise?			
Diet	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sleep	Please indicate how likely you would be to doze off or fall asleep in the following situations?			
	Sitting and reading?	Never (0) Slight (1) Moderate (2) High (3)	Total #:	
	Watching TV?	Never (0) Slight (1) Moderate (2) High (3)		
	Sitting inactive in a meeting, seminar or theatre, ect?	Never (0) Slight (1) Moderate (2) High (3)		
	As a passenger in a car for one hour?	Never (0) Slight (1) Moderate (2) High (3)		
	Lying down to rest in the afternoon?	Never (0) Slight (1) Moderate (2) High (3)		
	While having a relaxed conversation?	Never (0) Slight (1) Moderate (2) High (3)		
Sitting quietly after lunch?	Never (0) Slight (1) Moderate (2) High (3)			
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

	Do you have an Advance Directive and/or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Maternal</i>			
<input type="checkbox"/> M		Grandmother			
<input type="checkbox"/> F		<i>Paternal</i>			
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Paternal</i>			

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

Period every days

Heavy periods, irregularity, spotting, pain, or discharge? Yes No

Number of pregnancies Number of live births

Are you pregnant or breastfeeding? Yes No

Have you had a D&C, hysterectomy, or Cesarean? Yes No

Date of last pap & rectal exam?

Date of last pap and rectal exam?

Date of your last bone density test?

MEN ONLY

Do you usually get up to urinate during the night? Yes No

If yes, # of times

Do you feel pain or burning with urination? Yes No

Any blood in your urine? Yes No

Do you feel burning discharge from penis? Yes No

Has the force of your urination decreased? Yes No

Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any testicle pain or swelling? Yes No

Date of last prostate and rectal exam?

Date of your last bone density?

Any other concerns?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort: Dizziness or Giddiness? Anxiety? ADD/ADHD? Have you had laser eye surgery within 90days? Are you getting the full benefit from your medications?
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	
Syncope / Collapse?	Vertigo?	
Depression?	Migraines?	
Asthma?		
Do you have a pacemaker?	Do you have low blood pressure?	
Do you have a defibrillator?	Are you taking 3 or more medications?	
Do you have any upcoming procedures?		

POLICIES

Thank You for choosing Woodlands Internists, P.A. as your healthcare provider. We are committed to taking care of every aspect of your health. Your clear understanding of our policies is important to our professional relationship. We ask that you carefully read and initial each statement, then please sign at the bottom.

We require a copy of all insurance cards and ask that you present those at each visit along with your driver's license or photo ID.

INSURANCE: _____

The patient is responsible for knowing their insurance benefits and if you have a deductible or copayment. If you have an HMO policy YOU MUST change your PCP to one of our providers before your visit. We will gladly file your insurance claims on your behalf. We will not become involved in disputes between you and your insurance regarding coverage and/or policy benefits. **PAYMENT IS DUE AT TIME OF SERVICE. Any balances on your account are due prior to being seen by our providers.**

RETURNED CHECKS: _____

There will be a \$35 service fee on all dishonored checks. If payment is not received with full amount of check plus service fee within 10 days your information will be filed with The Montgomery County Hot Check Division. If you have any occurrences we will no longer be able to accept checks from you.

APPOINTMENTS: _____

When a patient arrives late it is important to stay on schedule. If you arrive more than 15 minutes late you may be asked to reschedule 24hrs in advance. For diagnostic testing and procedures, a fee of \$50 will be added to your account unless we have been notified 24 hrs in advance.

PRESCRIPTIONS: _____

Refills: It is the patient's responsibility to contact their pharmacy 5 days prior to running out of medications. Refills may take 3-4 days to be refilled. Please do not leave multiple messages for this may slow down the process.

Triplicates: Patients who receive triplicate medication for controlled substances must be seen every 90 days unless the provider has approved in order to receive their monthly prescriptions. Each prescription must be picked up by the patient or have a signed release plus proof of ID. There is a \$5 fee for each monthly script pickup. If a prescription is lost or not filled within the allowed time frame and we have to issue a new prescription a \$10 fee will be charged. **For monitoring purposes a urine toxicology screen is mandatory for all patients receiving triplicates.**

Controlled Medications: All patients that receive chronic pain medications must be seen every month by our providers unless prior approval has been documented. Each patient is required to sign an agreement that they will not receive medications from another facility or doctor. **For monitoring purposes a urine toxicology screen is mandatory for all patients receiving controlled medication.** Medications will only be done during business hours and not through our answering service.

MEDICAL RECORDS: _____

There is a \$25 fee for the first 20 pages of any medical record and must be paid prior to release. A signed medical records release form must be signed and 72 hr advance request is required. For any forms that need to be filled out and signed by a physician a \$25 fee must be paid in advance and a 72 hr advance notice is required. This includes FMLA, disability, medical supplies, or any formal document needing a physician letter.

REFERRALS AND/OR AUTHORIZATIONS: _____

Please allow 72 hours for all referrals and authorizations to be processed.

MINORS: _____

All patients under the age of 18 years of age, will need to be accompanied by a parent or legal guardian. Parent or legal guardian must be present through the entire duration of the appointment. If a parent or legal guardian is unavailable to accompany the patient, then a MEDICAL TREATMENT AUTHORIZATION form must be completed giving another adult permission to accompany the patient

Please list the individuals who we are allowed to discuss medical information with:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Do you consent to a medical exam and any procedures or test deemed necessary by our providers while you are in our office? YES/ NO

Do you consent Woodlands Internists to leave test result information on your voicemail? YES /NO

Do you consent for our office to release medical information to any specialist that we refer you to or that you are currently being treated by?
YES/NO

Please list all specialists that you are currently being treated by:

Physician: _____	Specialty: _____	Phone #: _____
Physician: _____	Specialty: _____	Phone #: _____
Physician: _____	Specialty: _____	Phone #: _____
Physician: _____	Specialty: _____	Phone #: _____

I have read, understand and agree with all of Woodlands Internists PA policies and procedures:

Print name : _____ **Signature:** _____ **Date:** _____

