CLOSE FAMILY MEDICINE

Patient Name_____ MRN_____ Date _____

Physical Exam Waiver

Dear Patient:

You are scheduled today for your Annual Preventative Medicine visit, also referred to as an Annual Physical.

Please know that your insurance may only cover this service once every 365 days. If you have received this service from another provider in the last 375 days you may be charged for this visit.

The Annual Preventative Medicine visit includes the following:

- An age focused history and exam that is not part of disease management.
- Counseling, guidance and risk factor reduction.
- Ordering of routine tests such as screening colonoscopy, screening labs, and radiological services to identify potential problems.

The Annual Preventative visit does not include the below services. If you require these services today, please be aware your insurance may require that you pay a copay for today's visit. Please let your provider know if you do not want these services.

- Evaluation and or management of new or ongoing problems that would require further testing or discussion. This may include a more problem focused physical exam, ordering of diagnostic tests, prescription drug management, referring or discussing your case with another specialist, or simply providing counseling related to a known health issue.

If you have any questions regarding this information, please see the front desk staff.

I have read and understand this information:

Patient Signature_____ Date _____

Patient Name_____ MRN_____ Date _____

For Woman:

Preventative Health History: Please circle or write in your answer

Have you ever had a transfusion or blood exposure?	Yes	No	
When was your last tetanus shot?			
Have you had a flu shot in the last year?	Yes	No	
Have you had a colonoscopy	Yes	No	
When was last PAP smear?			
Have you had an abnormal PAP smear?	Yes	No	When?
Have you ever had a mammogram?	Yes	No	
Was last mammogram normal?	Yes	No	Why?

Menstrual History:

Do you have any bleeding or spotting?	Yes	No
Date of last menstrual period:		

Pregnancy History:

1. Number of pregnancies: _____
2. Number of live births: _____
3. Number of miscarriages: _____
4. Number of abortions: _____
5. Number of ectopic (tubal pregnancies)_____

Sexual History:

1. Have you had sex with [ ] Men [ ] Women [ ] both [ ] never sexually active [ ] not currently
2. Are there any problems or anything else you want to discuss? Yes No

_____

2. Contraception:

Birth control pills [ ] condoms [ ] DepoProvera [ ] Diaphragm [ ] Foam/Jelly [ ] IUD [ ] none [ ] NuvaRing [ ] Patch [ ] Rhythm method [ ] Subcutaneous implants [ ] Tubal ligation [ ] Withdrawal [ ] Post-menopausal [ ]

SITE NAME

PRINT PATIENT NAME _____ PT DOB _____ ☐Female ☐Male DATE _____ MRN _____

SOCIAL QUESTIONNAIRE

These are questions about you and your family situation that may affect your health. It is also possible we may be able to use your answers to connect you with services available to you. Please check all correct response(s) for each question.

1. On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?
   ☐ 0 days ☐ 1 day ☐ 2 days ☐ 3 days
   ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days
   ☐ Patient refused
2. On average, how many minutes do you engage in exercise at this level?
   ☐ 0 min ☐ 10 min ☐ 20 min ☐ 30min ☐ 40min
   ☐ 50min ☐ 60min ☐ 70min ☐ 80min ☐ 90 min
   ☐ 100min ☐ 110min ☐ 120min ☐ 130min
   ☐ 140min ☐ 150+min ☐ Patient refused
3. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
   ☐ Not hard at all ☐ Hard
   ☐ Not very hard ☐ Very hard
   ☐ Somewhat hard ☐ Patient refused
4. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
   ☐Yes ☐ No ☐ Patient refused
5. In the last 12 months, how many places have you lived? _____
6. In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now) ?
   ☐Yes ☐ No ☐ Patient refused
7. In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?
   ☐Yes ☐ No ☐ Patient refused
8. In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?
   ☐Yes ☐ No ☐ Patient refused
9. Within the past 12 months, you worried that your food would run out before you got the money to buy more?
   ☐ Never true ☐ Sometimes true
   ☐ Often true ☐ Patient refused
10. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?
    ☐ Never true ☐ Sometimes true
    ☐ Often true ☐ Patient refused
11. Do you feel stress – tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time – these days?
    ☐ Not at all ☐ Only a little
    ☐ To some extent ☐ Rather much
    ☐ Very much ☐ Patient refused
12. In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
    ☐ Never ☐ Once a week
    ☐ Twice a week ☐ Three times a week
    ☐ More than three times a week
    ☐ Patient refused
13. How often do you get together with friends or relatives?
    ☐ Never ☐ Once a week
    ☐ Twice a week ☐ Three times a week
    ☐ More than three times a week
    ☐ Patient refused
14. Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?
    ☐Yes ☐ No ☐ Patient refused
15. How often do you attend meetings of the clubs or organizations you belong to?
    ☐ Never ☐ 1 to 4 times per year
    ☐ More than 4 times per year
    ☐ Patient refused
16. Are you married, widowed, divorced, separated, never married, or living with a partner?
    ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
    ☐ Never married ☐ Living with Partner
    ☐ Patient refused

Continued on next page

SITE NAME

PRINT PATIENT NAME _____ PT DOB _____ ☐Female ☐Male DATE _____ MRN _____

SOCIAL QUESTIONNAIRE

These are questions about you and your family situation that may affect your health. It is also possible we may be able to use your answers to connect you with services available to you. **Please check all correct response(s) for each question.**

17. **Within the last year, have you been afraid of your partner or ex-partner?**
    ☐Yes ☐ No ☐ Patient refused

18. **How often do you have a drink containing alcohol?**
    ☐ Never ☐ Monthly or less
    ☐ 2-4 times a month ☐ 2-3 times a week
    ☐ 4 or more times a week
    ☐ Patient refused

19. **How many drinks containing alcohol do you have on a typical day when you are drinking?**
    ☐ Patient does not drink ☐ 1 or 2
    ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9
    ☐ 10 or more ☐ Patient refused

20. **How often do you have six or more drinks on one occasion?**
    ☐ Never ☐ Less than monthly
    ☐ Monthly ☐ Weekly
    ☐ Daily or almost daily ☐ Patient refused

Site Name

PRINT PATIENT NAME _____ PT DOB _____ □Female □ Male _____ MRN

Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please 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 of 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
10. How difficult have those 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

Add column: _____ + _____ + _____

TOTAL: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	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?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Arizona Community Physicians, P.C.
Adult
Release of Information Form

Account #_____

Patient Name _____ DOB_____ Date_____

Guardian Name _____ Contact Number: _____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship _____ Contact Number_____

Name/relationship _____ Contact Number_____

Name/relationship _____ Contact Number_____

By providing the below phone #'(s) you are giving permission, to leave appointment information or detailed information regarding, lab results, radiological results or any other imperative information on the phone # indicated below

Cell/Mobile voice mail _____ (Phone #)

Home voice mail_____ (Phone #)

DO NOT RELEASE Information to the following people: _____

I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Name Patient/Guardian: _____ Signature _____Date_____

The information provided on this form will stay in effect until updated by the patient