| | |
|---|---|
| **Original Date:** | July 16, 2018 |
| **Dates Revised:** | |

# 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.):* ☐ M ☐ F | | **DOB:** |
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | | |
| **Previous or referring doctor:** | | **Date of last physical exam:** |

## PERSONAL HEALTH HISTORY

| | | |
|---|---|---|
| **Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio | | |
| **Immunizations and dates:** | ☐ Tetanus | ☐ Pneumonia |
| | ☐ Hepatitis | ☐ Chickenpox |
| | ☐ Influenza | ☐ MMR *Measles, Mumps, Rubella* |

**List any medical problems that other doctors have diagnosed**

**Surgeries**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Other hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| | | |
|---|---|---|
| **Have you ever had a blood transfusion?** | ☐ Yes | ☐ No |

*Please turn to next page*

# Prairie View Family Care – 7641 McLaughlin Rd Peyton CO 80831

| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | |
|---|---|---|
| Name the Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Allergies to medications** | | |
| Name the Drug | Reaction You Had | |
| | | |
| | | |
| | | |

## 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 minutes) | | | | | |
| **Diet** | Are you dieting? | | | | ☐ Yes | ☐ No |
| | If yes, are you on a physician prescribed medical diet? | | | | ☐ Yes | ☐ No |
| | # of meals you eat in an average day? | | | | | |
| | Rank salt intake | ☐ Hi | ☐ Med | ☐ Low | | |
| | Rank fat intake | ☐ Hi | ☐ Med | ☐ 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 drinking? | | | | ☐ Yes | ☐ No |
| **Tobacco** | Do you use tobacco? | | | | ☐ Yes | ☐ No |
| | ☐ Cigarettes – pks./day | | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years | ☐ Or year quit | | | | |

| | | | |
|---|---|---|---|
| **Drugs** | Do you currently use recreational or 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 trying for a pregnancy 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 |

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| **Sibling** | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | | |
| | ☐ M ☐ F | | **Grandmother** *Paternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Paternal* | | |

## MENTAL HEALTH

| | | |
|---|---|---|
| Is stress a major problem for you? | ☐ Yes | ☐ No |
| Do you feel depressed? | ☐ Yes | ☐ No |
| Do you panic when stressed? | ☐ Yes | ☐ No |
| Do you have problems with eating or your appetite? | ☐ Yes | ☐ No |
| Do you cry frequently? | ☐ Yes | ☐ No |
| Have you ever attempted suicide? | ☐ Yes | ☐ No |
| Have you ever seriously thought about hurting yourself? | ☐ Yes | ☐ No |
| Do you have trouble sleeping? | ☐ Yes | ☐ No |
| Have you ever been to a counselor? | ☐ Yes | ☐ No |

# Prairie View Family Care – 7641 McLaughlin Rd Peyton CO 80831

## WOMEN ONLY

| | | |
|---|---|---|
| Age at onset of menstruation: | | |
| Date of last menstruation: | | |
| Period every days | Sexual Preference: | |
| 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 |
| Any urinary tract, bladder, or kidney infections within the last year? | ☐ Yes | ☐ No |
| Any blood in your urine? | ☐ Yes | ☐ No |
| Any problems with control of urination? | ☐ Yes | ☐ No |
| Any hot flashes or sweating at night? | ☐ Yes | ☐ No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | ☐ Yes | ☐ No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | ☐ Yes | ☐ No |
| Date of last pap and rectal exam? | Date of last mammogram: | |

## MEN ONLY

| | | |
|---|---|---|
| Do you usually get up to urinate during the night? | ☐ Yes | ☐ No |
| If yes, # of times | Sexual Preference: | |
| 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 difficulty with erection or ejaculation? | ☐ Yes | ☐ No |
| Any testicle pain or swelling? | ☐ Yes | ☐ No |
| Date of last prostate and rectal exam? | | |

## OTHER PROBLEMS

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

| | | |
|---|---|---|
| ☐ Skin | ☐ Chest/Heart | ☐ Recent changes in: |
| ☐ Head/Neck | ☐ Back | ☐ Weight |
| ☐ Ears | ☐ Intestinal | ☐ Energy level |
| ☐ Nose | ☐ Bladder | ☐ Ability to sleep |
| ☐ Throat | ☐ Bowel | ☐ Other pain/discomfort: |
| ☐ Lungs | ☐ Circulation | |

# The CRAFFT Questionnaire (version 2.1)

**To be completed by patient**

Please answer all questions **honestly**; your answers will be kept **confidential**.

## During the PAST 12 MONTHS, on how many days did you:

| | | |
|---|---|---|
| **1.** | Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none. | ☐ # of days |
| **2.** | Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none. | ☐ # of days |
| **3.** | Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none. | ☐ # of days |

**READ THESE INSTRUCTIONS BEFORE CONTINUING:**

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

| | | No | Yes |
|---|---|---|---|
| **4.** | Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | ☐ | ☐ |
| **5.** | Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in? | ☐ | ☐ |
| **6.** | Do you ever use alcohol or drugs while you are by yourself, or **ALONE**? | ☐ | ☐ |
| **7.** | Do you ever **FORGET** things you did while using alcohol or drugs? | ☐ | ☐ |
| **8.** | Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use? | ☐ | ☐ |
| **9.** | Have you ever gotten into **TROUBLE** while you were using alcohol or drugs? | ☐ | ☐ |

**NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:**
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

# Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

| | | |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | No | Yes |
| 2. Do you abuse more than one drug at a time? | No | Yes |
| 3. Are you unable to stop using drugs when you want to? | No | Yes |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | No | Yes |
| 5. Do you ever feel bad or guilty about your drug use? | No | Yes |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | No | Yes |
| 7. Have you neglected your family because of your use of drugs? | No | Yes |
| 8. Have you engaged in illegal activities in order to obtain drugs? | No | Yes |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | No | Yes |
| 10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? | No | Yes |
| | 0 | 1 |

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

| I | II | III | IV |
|---|---|---|---|
| 0 | 1-2 | 3-5 | 6+ |

*(For the health professional)*

**Scoring and interpreting the DAST:**

"Yes" responses receive one point each and are added for a total score. The score correlates with a zone of use that can be circled on the bottom right corner of the page.

| Score | Zone of use | Indicated action |
|---|---|---|
| **0** | **I – Healthy**<br>(no risk of related health problems) | None |
| **1 - 2,** plus the following criteria:<br><br>No daily use of any substance; no weekly use of drugs other than cannabis; no injection drug use in the past 3 months; not currently in treatment. | **II – Risky**<br>(risk of health problems related to drug use) | Offer advice on the benefits of abstaining from drug use. Monitor and reassess at next visit. Provide educational materials. |
| **1 - 2** (without meeting criteria) | | Brief intervention |
| **3 - 5** | **III – Harmful**<br>(risk of health problems related to drug use and a possible mild or moderate substance use disorder) | Brief intervention or<br>Referral to specialized treatment |
| **6+** | **IV – Severe**<br>(risk of health problems related to drug use and a possible moderate or severe substance use disorder) | Referral to specialized treatment |

**Brief intervention:** Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as screening. The recommended behavior change is to abstain from illicit drug use.

Patients with numerous or serious negative consequences from their substance use, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up.

**Referral to specialized treatment:** A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

Acknowledgement of Notice of Privacy Practices

Prairie View Family Care endorses supports and participates in Electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of test and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel and opt-out choice at any time. I have been given the opportunity to review the Notice of Privacy Practices and acknowledge the Notice describes how my protected information may be used, disclosed and how I may gain access to my information.

The preferred phone number for messages: _____ Please check appropriate boxes below.

_____ Leave a message to call back

_____ Okay to leave a detailed message

_____ Okay to speak with the following person(s) _____

By signing below, I agree to the privacy practices as stated.

---

Patient or Guardian Printed Name

---

Patient or Guardian Signature

# Prairie View Family Care – 7641 McLaughlin Rd Peyton CO 80831

Thank you for choosing Prairie View Family Care for your medical needs. Our primary mission is to deliver the best medical care available. An important part of the mission is making the cost of your optimal care easy and manageable. We offer several payment options to include cash, check and charge. Patients without verifiable insurance are responsible for payment of all services rendered at the time of service.

We participate with Medicare, Medicaid and most insurance plans. We will file these claims for you. Patients are responsible for any deductibles, coinsurance or co-pay amounts owed at the time of service. Please be aware that we will bill you for those portions not covered by Medicare and have you sign an Advanced Beneficiary Notice.

Please realize:

1. Your insurance is a contract between **you and your insurance company**. We are not a party to that contract therefore; any portion of our fees not covered may be the responsibility of the patient.
2. If you **"No Show"**for an appointment and do not cancel at least **24 hours** prior to your appointment, you are subject to a **$50.00 fee**, which is not payable by insurance.
3. **Returned checks** are subject to a **$25.00** service charge.
4. If the account is referred to a collection agency, the patient shall pay an additional collection fee of **33.3%** of the principle balance plus all reasonable attorneys' fees and all Court cost of Prairie View Family Care, LLC to any action brought to enforce this Agreement.

Regardless of insurance payment, the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. In the event your account is not paid within 30 days of treatment or according to an agreed-upon plan, interest will be assessed at the rate of **18% per annum** on the unpaid balance. If your account balance becomes delinquent, it may be forwarded to an outside collection agency without notice. If this occurs, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs. **You are ultimately responsible for payment on your account.**

By signing this financial policy, responsibility is accepted. This will remain in effect until revoked in writing by Prairie View Family Care, LLC.

_____

Patient or Guardian Printed Name

_____ _____

Patient or Guardian Signature Date