Enhanced Wellness of Oak Grove, PLLC ~ Betty 'Laurie' Ryba, MSN FNP-BC
56 98 Place Blvd, Hattiesburg, MS 39402 P: 601-264-7286 / F: 601-450-4640 / EW_OG@yahoo.com / www.enhancedwellnessog.com

PATIENT INFORMATION

Name:_____Birth Date:_____/_____/_____

Preferred Name:_____ □ If <18 y/o (Parent/Guardian) Name/Relationship: _____

Social Security Number: _____ Sex: _____ Race: _____

Email Address: _____

Address:_____

City/State/Zip:_____

Primary Phone No:_____Home Phone:_____Cell Phone: _____

Family Account: _____

(names of other family members who are patients)

Marital Status: Single / Divorced / Separated / Widowed

- If married *Spouse Name:*_____Spouse Ph#: _____

Emergency Contact:_____Relationship:_____Phone:_____

Emergency Contact Address: _____

Who referred you: _____

List any other physicians you are currently seeing: _____

PLEASE INCLUDE A COPY OF ANY LAB WORK YOU HAVE HAD IN THE PAST 7 YEARS .

You can contact the provider that has the lab results and request they fax the labs to us at 601-450-4640.

EMPLOYMENT INFORMATION

Employer:_____Years:_____

Employer Address/City/State/ Zip:_____Phone:_____

Occupation: _____

PHARMACY INFORMATION

Pharmacy Name/Location:_____Phone: _____

INSURANCE AND PAYMENT INFORMATION

We will need a front & back copy of your insurance card(s) when you send in your paperwork. **If you have a PCP listed on your insurance card you will most likely need a referral approved by your insurance before we can see you. Please be sure to list your PCP if you have one**.

Primary Insurance Company: _____

Address/Ph:_____Payer ID_____

Policy#:_____ Member ID#_____Group#:_____Copay ($ or %)_____

Policy Holder/Guarantor Name:_____DOB-Policy Holder: _____

PCP and phone# (If applicable) _____

Secondary Insurance Company:_____

Address/Ph:_____Payer ID_____

Policy#:_____ Member ID#_____Group#:_____Copay ($ or %)_____

Policy Holder/Guarantor Name:_____DOB-Policy Holder: _____

Who is responsible for this bill? (Self / Guarantor / Parent/ Other)_____Relationship: _____

HISTORY OF PRESENT ILLNESS

Reason for Visit:_____

Please list all current medications: (Feel free to write in margin if you need more room)

MEDICATION	DOSAGE (ml/mg/etc)	Times per day	Start Date

List all conditions you have been diagnosed with by using (✘) and any areas of concern with a (✓) and date of diagnosis next to condition.

HISTORY *(Feel free to write in the margin/on back for any additional comments)*

CARDIOVASCULAR	☐ G-U/Reproductive	☐ Polycystic Ovarian disease	☐ Osteoporosis
☐ Atrial fibrillation	☐ Chronic renal failure	☐ HIV (+)	☐ Goiter
☐ Defibrillator	☐ Glomerulonephritis	☐ AIDS	**HEMATOLOGIC**
☐ Congestive heart failure	☐ Recurrent urinary tract infections	☐ STDS Other	☐ Pernicious anemia
☐ Blood clots	☐ Kidney stones	**MUSCULOSKELETAL**	☐ Diabetes
☐ Angina	**CANCER**	☐ Fibromyalgia	**OTHER**
☐ Heart attack	☐ Brain tumor	☐ Chronic fatigue syndrome	☐ Vitamin D deficiency
☐ Balloon or stent	☐ Breast cancer	☐ Fracture(s) List if any:	☐ Vitamin B12/Folate deficiency
☐ High cholesterol	☐ Cervical cancer	☐ Gout	☐ Iron deficient Anemia
☐ High triglycerides	☐ Colon cancer	☐ Osteoarthritis	☐ Nutritional Anemia
☐ High blood pressure	☐ Uterine cancer	☐ Polymyalgia Rheumatic	☐ Thrombocytopenia
☐ Irregular heartbeat	☐ Liver cancer	☐ Rheumatoid Arthritis	☐ Coagulation/Blood clotting defect
☐ Aneurysm	☐ Leukemia	**ALLERGY/DERMATOLOGIC**	☐ Sickle Cell
☐ Stress test date:	☐ Lung cancer	☐ Seasonal Allergies	☐ Premature Menopause
☐ Heart catheter date:	☐ Lymphoma	☐ Alopecia	☐ Lipoprotein deficiency
RESPIRATORY	☐ Melanoma	☐ Psoriasis (skin disease)	☐ Sulfur Bearing Amino Acid Disorder
☐ Asthma	☐ Ovarian cancer	☐ Frequent sinusitis	☐ Homocystinuria
☐ Chronic bronchitis/COPD/Emphysema	☐ Kidney cancer	**NEUROLOGICAL**	☐ MTHFR
☐ Pneumonia	☐ Skin cancer	☐ Stroke	☐ Abnormal Blood Findings
☐ Blood clot to lung	☐ OTHER: (list)	☐ Alzheimer's	
☐ Sleep apnea	**PSYCHOLOGICAL**	☐ Spinal disc disorder	**Long Term Medication Use**
☐ TB	☐ Anxiety	☐ Migraine headaches	☐ Birth Control
GASTROINTESTINAL	☐ Anorexia Nervosa	☐ Tension headaches	☐ Non-Steroid Anti-inflammatory
☐ Stones of the gall bladder	☐ Bipolar Disorder	☐ Meningitis	☐ Antithrombotic/Antiplatelets
☐ Disease of the liver	☐ Bulimia	☐ Multiple Sclerosis	☐ Hormone Therapy
☐ Polyp of the colon	☐ Depression	☐ Parkinson's Disease	☐ Insulin
☐ Celiac Disease	☐ Obsessive-Compulsive Disorder	☐ Neuropathy	☐ Inhaled Steroid
☐ Crohn's disease	☐ Schizophrenia	☐ Seizure disorder	☐ Systemic Steroids (i.e. prednisone)
☐ Reflux	**EYES**	☐ Mini stroke	☐ Peptic ulcer disease
☐ Hepatitis	☐ Cataracts	**ENDOCRINE**	☐ Opioid Analgesics/Narcotics
☐ Irritable bowel	☐ Glaucoma	☐ Type 1 Diabetes	
☐ Inflammation of the pancreas	**GYNECOLOGICAL/HORMONE**	☐ Type 2 Diabetes	**Other:**
☐ Peptic ulcer disease	☐ Erectile Dysfunction	☐ Cushing's Disease	
☐ Gastric ulcer disease	☐ Endometriosis	☐ Hyperthyroidism (overactive)	
☐ Ulcerative colitis	☐ Amenorrhea (3+ missed periods)	☐ Hypothyroidism (underactive)	

Patient Name: _____

LIST ALLERGIES (MEDICATIONS and/or ENVIRONMENTAL)	REACTION

SURGERIES	APPRX DATE / LOCATION

PROCEDURES	APPRX DATE / LOCATION

FAMILY HISTORY

List as Alive or Deceased; if deceased list the cause of death/year

Father (F) _____

Mother (M)_____

Brother (B) _____

Sister (S) _____

FAMILY MEDICAL HISTORY

Please use these abbreviations above to answer questions about your family medical history: (F, M, B, S)

High Cholesterol: _____ High Blood Pressure: _____ Aneurysm: _____ Ulcers: _____

Kidney Stones:_____ Stroke:_____ Alzheimer's:_____ Diabetes: _____

Thyroid: _____ Menopause under 40yo: _____ Cancer (list type): _____

SOCIAL HABITS

Alcohol Use	❍ Non-drinker	❍ Rarely	❍ Socially	❍ Regularly

How often did you have a drink containing alcohol in the past year?	❍ Never	❍ Monthly or less	❍ 2-4x month	❍ 2-3x week	❍ +4x week

How many drinks did you have on typical day when you were drinking in the past?	❍ None	❍ 1 - 2	❍ 3 - 4	❍ 5 - 6	❍ 7 – 9	❍ 10+

Tobacco Use	❍ Never smoked	❍ Former/Past User	❍ Current User

Tobacco Type	Smoker	Dip	Vape/e-Cig	Other: _____

Year Started using tobacco: _____	Year Stopped Using tobacco

Caffeine Use	❍ Never	❍ Rarely	❍ Occasionally	❍ Daily
Exercise	❍ Never	❍ Seldom	❍ Weekly	❍ Daily	Type: _____
Drug Use	❍ Yes ❍ No			
Sexually Active	❍ Yes ❍ No			
# of Living Children				

Pets: (List type-dog, cat, # of each) _____

Female Only

PREGNANCY HISTORY	# of times
Times Pregnant	
Premature Births	
Miscarriages	
Abortions	
Live Births	

MENSTRUAL HISTORY	
Do you have pain with menses	❍ Yes ❍No
Do you have symptoms that occur prior to menses/PMS/Irregular menses?	
Do you have Menopausal symptoms	❍ Yes ❍No
If Yes, approximate date/age symptoms started	
Date of last period	
Age when period started	
Avg # of days period last	
Number of days between period	
Present contraceptive method	
How long have you used this contraceptive method	

Date of last pap smear and location completed	
Any abnormal pap smears in past	
If so, when:	

Date of last mammogram and location completed	

Have you had a complete hysterectomy	❍ Yes ❍No
Have you had a partial hysterectomy	❍ Yes ❍No
If YES please explain (ie left ovary removed only)	

Male Only

Prostate Health	Not at all (0)	Less than 1 in 5 (1)	Less than half (2)	About half (3)	More than half (4)	Almost always (5)	Score
Incomplete emptying: Over the past month, how often did you have a sensation of not emptying your bladder completely after you finished urinating?							
Frequency: Over the past month, how often have you needed to urinate again less than two hours after you finished urinating?							
Intermittency: Over the past month, how often have you found that you stopped and started your urine stream several times when you urinated?							
Urgency: Over the last month, how difficult have you found it to postpone urination?							
Weak stream: Over the past month, how often have you had a weak urinary stream?							
Straining: Over the past month, how often have you had to push or strain to begin urination?							
Nocturia: Over the past month, how many times did you typically get up to urinate from the time you went to bed until the time you got up in the morning?							
Total score: 0-7 Mild symptoms; 8-19 moderate symptoms; 20-35 severe symptoms							

Quality of Life due to Urinary Symptoms	**Delighted**	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Date of Last Prostate Rectal Exam: _____

Date of last Prostate-specific antigen (PSA) Lab: _____

Have you ever had an abnormal Prostate-specific antigen (PSA)? ❍ Yes ❍ No

ENHANCED WELLNESS OF OAK GROVE

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POLICIES / PROCEDURES / CONSENTS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have the right to read a copy of Enhanced Wellness of Oak Grove's (the "Practice") Notice of Privacy Practices (the "Notice"). I can view it in the clinic by request. I understand that I may address any questions or concerns I may have about the Notice.

PRESCRIPTION REFILL POLICY

I understand that prescription refills and follow up care are my responsibility, and that I should call ENHANCED WELLNESS OF OAK GROVE, PLLC at least 1 week before I need a prescription refill. Refills are provided only at provider discretion and can take up to 3 business days to review/approve. ***We DO NOT do same day prescription refills.***

NO SHOW / LATE / MISSED APPOINTMENTS POLICY

We understand that circumstances may arise that do not allow you to keep your appointment or that you may forget once in a while. Please remember to be courteous to us and the other patients by calling at least **24 hours prior** to your appointment time to **cancel** if you cannot make it. This will allow us to serve our patients better. Patients arriving more than 15 minutes late for their appointments will be counted as a no show, and they will need to reschedule their appointments. We enforce a 3-strike policy for missed/late/no show appointments. After your 3rd strike we will no longer be able to serve you as your health care provider. *Missed appointments cost us all time, effort, and money. If you have any questions, please ask any of the staff or your provider.*

INTEGRATIVE MEDICINE CONSENT

I understand that Enhanced Wellness of Oak Grove, PLLC is an integrative medicine practice focusing on whole body health and wellness by using naturally healing methods/treatment. Integrative medicine includes recommendations for nutrition, supplements/vitamins, and bioidentical hormone evaluations (estradiol, progesterone, testosterone, thyroid). I understand that some services may be considered non-traditional, nonconventional or alternative medicine.

GENERAL CONSENT FOR CARE AND TREATMENT

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. I understand I will be responsible for the cost of any treatment, procedures, or diagnostics testing (IE-lab work) if it is denied or not paid by my insurance. I understand I have the right to verify any cost before the testing is done as we cannot revoke any charges once services/treatment is completed. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request any health care providers, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____	_____
Patient Signature	Date	Patient Printed Name
_____	_____	_____
Guarantor/Responsible Party Signature	Date	Guarantor Responsible Party Printed Name

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name:_____ Date_____

It is the intention of ENHANCED WELLNESS OF OAK GROVE, PLLC to provide you with a clear understanding of our financial agreements and billing procedures in the hopes to prevent any misunderstanding. If you have any questions regarding these agreements, please notify the front office coordinator. Please take the time to read, initial, and sign the patient financial responsibility form.

_____If you have medical insurance, it is your responsibility to fill out the insurance details on the patient form. Please provide your insurance card to the front office coordinator to bill your insurance carrier completely and accurately. If benefits cannot be determined at the time of service, or when there is any doubt, payment in full is expected**. Please be advised that a medical insurance card does not inform our office of active coverages.**

_____Your insurance policy is a contract between you and your insurance company. We are not a party to that contract and therefore do not know the details or specific benefits allowed by your insurer. As a service to you and upon your request we can bill your insurance company. I understand it is my responsibility to verify my insurance coverages prior to my appointment including but not limited to obtaining a PCP referral or prior authorization (PA). If a referral is required, we need to have your referral reference number in hand prior to your appointment date. We cannot attain referrals on the appointment date.

_____You are responsible for payment of any unmet deductible, co-payment, and co-insurance as determined by your contract with your insurance carrier. **We expect these payments when services are rendered.** Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim you will be responsible for your balance in full.

_____There are normal and expected times that we will need to bill your insurance company. However, if there becomes a time when the costs of completing your billing are over and above the usual and customary time spent to process and follow-up on a claim, we will contact you. If at this time payment has not been received by your insurance carrier payment will be expected in full by you and you may pursue collecting personally. If payment is received from your insurance carrier you will be reimbursed.

_____Once payment is received on your behalf from your insurance carrier any balances due for unmet deductible, co-payments, and co-insurance that have not already been collected will be billed to you. After thirty (30) days of the first bill, a $5.00 annual and/or minimum of $5.00 per month finance charge will begin to apply on your account. Any bill over sixty (60) days past due will be subject to collection procedures. If you fail to make payment arrangements or set up a payment plan, your account will be turned over to a professional collection agency.

_____Upon receipt of payment from your insurance provider, you may end up with a credit balance. Any overpayment will remain on your account as a credit to be used towards future services or material purchases. If you would like to be issued a refund, please let us know and we will issue a check within thirty (30) days of your verbal or written request.

_____There will be a $30.00 service charge for any returned check. After receiving a returned check, we will no longer accept a check on your account. Payments will have to be made using cash or credit card.

Assignment of Benefits

I have read the above policy regarding my financial responsibility to ENHANCED WELLNESS OF OAK GROVE, PLLC for services performed to myself or the above-named patient. I authorize my insurer to pay any benefits directly to ENHANCED WELLNESS OF OAK GROVE, PLLC. I agree to pay the full and entire amount of all bills incurred by the above-named patient, as well as any amount due after my insurance carrier has made a payment.

_____	_____	_____
Patient Signature	Date	Patient Printed Name
_____	_____	_____
Guarantor/Responsible Party Signature	Date	Guarantor Responsible Party Printed Name

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Authorization for Release of Information

Patient Name:_____ DOB: _____

ENHANCED WELLNESS OF OAK GROVE, PLLC is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other: _____
☐ Spouse/Other (provide name & phone number) _____	☐ Financial ☐ Medical
☐ Parent/Other (provide name & phone number) _____	☐ Financial ☐ Medical
☐ Email communication (provide email address) * _____	☐ Financial ☐ Medical ☐ Breach Notification

** I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.*

___ Check here if there is no person that you wish to release your information to.

Patient Information

I understand that 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 as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. **This authorization shall be in effect until revoked by the patient.**

_____ _____

Signature of Patient / Parent / or Personal Representative Date

_____

Description of other Representative if not patient (IE-Parent, Legal Guardian

Annual Health Risk Assessment

Today's Date: _____

Patient Name: _____

DOB: _____

TOBACCO CONTROL	
1. Are you a	❍ Current smoker/ vape/ e-cigarette (go to 4) ❍ Former smoker/ vape/ e-cigarette (go to 2, 3, 5) ❍ Never smoker (go to 5) ❍ Uses tobacco in other forms (dip, pipe, etc) go to 4
2. If former smoker: Date or apprx date you quit? Reason	Date: _____ Reason: ❍ Medical ❍ Personal ❍ Religious
3. If former smoker: How long has it been since you last smoked?	❍ < 1 month ❍ 1 to 3 months ❍ 3 to 6 months ❍ 6-12 months ❍ 1 to 5 years ❍ 5-10 years ❍ 10+ years
4. Additional Findings: Current Tobacco User	❍ Chain Smoker (1 after another) ❍ Chews fine cut tobacco ❍ Chews loose leaf tobacco ❍ Chews plug tobacco ❍ Chews twist tobacco ❍ Trivial cigarette smoker (1 per day) ❍ Light tobacco smoker (1-9 per day) ❍ Moderate tobacco smoker (10-19 per day) ❍ Heavy tobacco smoker (20-39 per day) ❍ Very Heavy cigarette smoker (40+ day) ❍ Pipe smoker ❍ Rolls own cigarettes ❍ Snuff user ❍ User of moist powdered tobacco ❍ User of e-cigarette / vape
5. Additional Findings: Current Tobacco Non-User	❍ Aggressive non-smoker / never smoker ❍ Current non-smoker / never smoker ❍ Current non-smoker but past smoking history ❍ Ex user of moist powdered tobacco ❍ Ex-cigar smoker ❍ Trivial cigarette smoker (1 per day) ❍ Ex-Light tobacco smoker (1-9 per day) ❍ Ex-Moderate tobacco smoker (10-19 per day) ❍ Ex-Heavy tobacco smoker (20-39 per day) ❍ Ex-Very Heavy cigarette smoker (40+ day) ❍ Ex-Pipe smoker ❍ Ex-chewed tobacco user ❍ Tolerant Ex-smoker ❍ Tolerant non-smoker ❍ Intolerant (uncomfortable) Ex-smoker ❍ Intolerant (uncomfortable) non-smoker

ALCOHOL (AUDIT-C)	
Did you have a drink containing alcohol in the past year?	❍ Yes ❍ No
If Yes: How often did you have a drink containing alcohol in the past year?	❍ Never ❍ Monthly or less ❍ 2-4x a month ❍ 2-3 times per week ❍ 4+ times a week
If Yes: How may drinks did you have on a typical day when you were drinking in the past year?	❍ 1 to 2 ❍ 3 to 4 ❍ 5 to 6 ❍ 7 to 9 ❍ 10+
If Yes: 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

PATIENT HEALTH				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	❍	❍	❍	❍
2. Feeling down, depressed, or hopeless?	❍	❍	❍	❍
3. Trouble falling or staying asleep, or sleeping too much	❍	❍	❍	❍
4. Feeling tired or having little energy?	❍	❍	❍	❍
5. Poor appetite or overeating?	❍	❍	❍	❍
6. Feeling bad about yourself of that you are a failure or have let you or your family down?	❍	❍	❍	❍
7. Trouble concentrating on things, such as reading newspaper or watching TV?	❍	❍	❍	❍
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?	❍	❍	❍	❍
9. Thoughts that you would be better off dead or of hurting yourself in some way?	❍	❍	❍	❍

Recommended Annual Counseling – Please check all that apply to you or that you are interested in receiving:

- ❍ Diet/Nutrition
- ❍ Physical Activity/Exercise
- ❍ Tobacco/Alcohol/Illicit Drug Use and quitting
- ❍ Emotional Health and social wellbeing and/or Depression/Anxiety
- ❍ Overall health at work
- ❍ Sexual behavior/risk/STI/Unintended pregnancy
- ❍ Domestic violence
- ❍ Chronic health disease (personal or family health risk factors)
- ❍ Injury Prevention
- ❍ Dental Oral Health

SCREENING CHECKLIST

Please list the approximate date and location of your last procedure or put you have never had in blank.

Colorectal Cancer screening options:

Fecal/Stool Occult blood test: _____

Colonoscopy (every 10 years): _____

Comp tomography/Flex sigmoidoscopy (every 5 year): _____

Bone Density (1x lifetime): _____

Male

Prostate Exam: _____

Female

Pap Smear: _____

Pelvic Exam: _____

Breast Exam: _____

Mammogram: _____

Lab Work

Lipid Panel (cholesterol): _____

Glucose: _____

Hemoglobin A1c: _____

Annual STI screening for sexually active (as recommended by age/gender/risk)

- ❍ Chlamydia, Syphilis, Gonorrhea, HIV, Hep B, Hep C

Date: _____

OTHER PROVIDERS

Please list any other Physicians or Health Care Providers you are seeing, their specialty and the last date you show them. (i.e. Dr --, cardiologist, 9/03/2021)

_____

_____

_____

_____

Date of your last eye exam: _____

Where/Who did your eye exam: _____

Please answer the following questions
If you need more space, please use the back of the page – if no changes please put no changes in blank

1. How do feel your overall health is?
   ❍ Excellent ❍ Good ❍ Fair ❍ Poor

2. How many different prescriptions are you taking?
   ❍ 0-3 ❍ 4-6 ❍ 7-10 ❍ 10+

3. Please list your current medications/supplements and dosage:
   _____
   _____
   _____
   _____

4. How is your oral health? (mouth/teeth including false teeth/dentures
   ❍ Excellent ❍ Good ❍ Fair ❍ Poor

5. Do you have a dentist you visit regularly?
   ❍ Yes ❍ No If Yes, name of dentist: _____

6. Have you been to the emergency room or admitted to the hospital within the last year?
   ❍ Yes ❍ No
   If yes, please list hospital and reason you were seen/admitted:
   _____
   _____
   _____
   _____

7. Do you feel you eat the proper servings of fruit, vegetables, fiber/whole grains, meat, fish or other proteins in your diet?
   ❍ Yes ❍ No

8. Do you feel you eat too much fried, high fat foods, or sugar sweetened drinks in your diet?
   ❍ Yes ❍ No

9. Do you exercise?
   ❍ Yes ❍ No
   If yes, please list type of exercise, intensity of exercise, times per week and number of minutes you exercise:
   _____
   _____
   _____
   _____

10. What is your living situation?
    ❍ Alone ❍ With spouse/family member ❍ With roommate ❍ Assisted living

11. How often do you get out and meet with family and friends or participate in church/clubs/activities?
    ❍ Often ❍ Sometimes ❍ Rarely ❍ Never

12. Do you use your seatbelt in your care?
    ❍ Always ❍ Sometimes ❍ Rarely ❍ Never

13. Do you have any problems with your hearing?
    ❍ Yes ❍ No

14. If Yes, do you currently use a hearing aid?
    ❍ Yes ❍ No

15. Has any of your medical, surgical, allergies, family history, or social history changed since your last visit? *(i.e. Illnesses, hospital stays, injuries, treatment, medical event/treatment for family member, hereditary disease, diet, hx of alcohol, tobacco, illicit drug use, physical activities/exercise)*

    _____
    _____
    _____
    _____

16. Has any of your psychosocial risks changed? *(i.e. Depression/life satisfaction, stress, anger, loneliness/social isolation, pain, fatigue, etc)*

    _____
    _____
    _____
    _____

17. Have any behavioral risks changed? *(i.e., tobacco use, physical activity/exercise, nutrition, diet, oral health, alcohol consumption, sexual health, motor vehicle safety (seatbelt use), home safety, etc)*

    _____
    _____
    _____
    _____

18. Have any daily living activities changed? *(i.e., can you do these alone or need help: dressing, feeding, toileting, grooming, physical ambulation – balance/risk of falls bathing etc)*

    _____
    _____

_____
_____

19. Have any instruments of daily living changed*? (i.e., can you do these alone or need help: shopping, food preparations, using telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, ability to handle finances. etc)*

    _____
    _____
    _____
    _____

20. Have any functional abilities or levels of safety changed? (i.e., hearing impairment (use of hearing aid), vision changes (use of glasses/contacts), activities of daily life, fall risk, home safety, do you use a cane, crutch, walker, wheelchair)

    _____
    _____
    _____
    _____

21. Are there any other changes or concerns that you have that we need to be aware of? Or do your family members or care givers have any concerns, or have they observed any cognitive impairments?

    _____
    _____
    _____
    _____

22. Have you experienced any changes in urination? (leakage/incontinence, going more frequently, waking up at night to urine, changes in stream)

    _____
    _____
    _____
    _____

ADVANCE DIRECTIVES

23. Do you have a health care power of attorney, or a living will? ❍ Yes ❍ No

24. Would you like more information? ❍ Yes ❍ No