

**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](mailto:EW_OG@yahoo.com) / [www.enhancedwellnessog.com](http://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)

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

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	<input type="radio"/> Non-drinker	<input type="radio"/> Rarely	<input type="radio"/> Socially	<input type="radio"/> Regularly		
How often did you have a drink containing alcohol in the past year?	<input type="radio"/> Never	<input type="radio"/> Monthly or less	<input type="radio"/> 2-4x month	<input type="radio"/> 2-3x week	<input type="radio"/> +4x week	
How many drinks did you have on typical day when you were drinking in the past?	<input type="radio"/> None	<input type="radio"/> 1 - 2	<input type="radio"/> 3 - 4	<input type="radio"/> 5 - 6	<input type="radio"/> 7 - 9	<input type="radio"/> 10+

Tobacco Use	<input type="radio"/> Never smoked	<input type="radio"/> Former/Past User	<input type="radio"/> Current User	
Tobacco Type	Smoker	Dip	Vape/e-Cig	Other: _____
Year Started using tobacco: _____	Year Stopped Using tobacco _____			

Caffeine Use	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Occasionally	<input type="radio"/> Daily	
Exercise	<input type="radio"/> Never	<input type="radio"/> Seldom	<input type="radio"/> Weekly	<input type="radio"/> Daily	Type: _____
Drug Use	<input type="radio"/> Yes <input type="radio"/> No				
Sexually Active	<input type="radio"/> Yes <input type="radio"/> No				
# of Living Children					

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

# Female Only

<b>PREGNANCY HISTORY</b>	<b># of times</b>
Times Pregnant	
Premature Births	
Miscarriages	
Abortions	
Live Births	

<b>MENSTRUAL HISTORY</b>	
Do you have pain with menses	<input type="radio"/> Yes <input type="radio"/> No
Do you have symptoms that occur prior to menses/PMS/Irregular menses?	
Do you have Menopausal symptoms	<input type="radio"/> Yes <input type="radio"/> 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	
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Have you had a complete hysterectomy	<input type="radio"/> Yes <input type="radio"/> No
Have you had a partial hysterectomy	<input type="radio"/> Yes <input type="radio"/> 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

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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 3<sup>rd</sup> 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

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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

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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.

<b>Entity to Receive Information.</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released.</b> Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other: _____
<input type="checkbox"/> Spouse/Other (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Parent/Other (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication (provide email address) * _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Breach Notification
<i>* 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.</i>	
___ <b>Check here if there is no person that you wish to release your information to.</b>	

### 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: \_\_\_\_\_

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

<b>ALCOHOL (AUDIT-C)</b>	
Did you have a drink containing alcohol in the past year?	<input type="radio"/> Yes <input type="radio"/> No
If Yes: How often did you have a drink containing alcohol in the past year?	<input type="radio"/> Never <input type="radio"/> Monthly or less <input type="radio"/> 2-4x a month <input type="radio"/> 2-3 times per week <input type="radio"/> 4+ times a week
If Yes: How many drinks did you have on a typical day when you were drinking in the past year?	<input type="radio"/> 1 to 2 <input type="radio"/> 3 to 4 <input type="radio"/> 5 to 6 <input type="radio"/> 7 to 9 <input type="radio"/> 10+
If Yes: How often did you have 6 or more drinks on one occasion in the past year?	<input type="radio"/> Never <input type="radio"/> Less than monthly <input type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> Daily or almost daily

<b>PATIENT HEALTH</b>				
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling down, depressed, or hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Feeling tired or having little energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Poor appetite or overeating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Feeling bad about yourself or that you are a failure or have let you or your family down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble concentrating on things, such as reading newspaper or watching TV?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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)*  
\_\_\_\_\_  
\_\_\_\_\_

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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)

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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)

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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?

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

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**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

**NOTICE OF PRIVACY PRACTICES and  
OFFICE POLICIES/CONSENTS/AUTHORIZATIONS**  
are posted at our website.

Online and PDF copies available at our website:  
<https://www.enhancedwellnessog.com/sms>

Return this form to our office by:

email: **ew\_og@yahoo.com**

fax: **601-450-4640**

Mail: **56 98-Place Blvd, Hattiesburg, MS 39402**