MDVIP | LONG LIVE HEALTHY

# PATIENT HEALTH HISTORY FORM DIRECTIONS AND VISIT DAY INSTRUCTIONS

**Prior to your Appointment:**

**STEP 1: Forms**

Please complete all the attached forms and bring them with you on the day of your visit.

**STEP 2: Labs**

Please have your labs drawn "at least" one week prior to your appointment if you would like to discuss your results at that time of you visit

***PLEASE FAST for 12 hours before your labs***.

~ **Enclosed** you will find your lab order which can be done prior to your visit.

****Note: Labs for Wellness Exam can ONLY be drawn at the***
***QUEST DIAGNOSTICS 805 Locust Street, Philadelphia, PA, 19107***
*Hours are: Mon-Fri: 7:00am – 3:30pm*
***Office is closed for Lunch from 12:00 pm – 1:00 pm***
*MDVIP Membership Fee includes the cost of the labs.*
*****If you take this lab slip to any other lab you WILL be charged an out of pocket fee***.

**STEP 3: (optional) MDVIP Patient Portal**

~ Available on the MDVIP portal is the *Interactive Health Assessment* that is a tool that will help you identify your health risks.

**If you do not have a username & password and would like one, please contact:**
***MDVIP Corporate at 1-866-696-3847 or online @ connect.mdvip.com/request-registration-key***

**On the Day of your Appointment:**

- Please do not wear any perfumes, lotions or oils, since they may interfere with an ECG tracing.

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New Patient Forms

**Name:**_______________________________________ **DOB:**_______________________________

**Date:**_______________________________________

Please complete these forms in advance of your appointment and bring them with you. Thank You.

What **problems** do you wish to discuss with the doctor during your evaluation today?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

***Do you have an Advance Directive? Yes / No***

Please list any **NEW** allergies to medications**:** Drug / Reaction

_______________ __________________ ___________________ ___________________
_______________ __________________ ___________________ ___________________
_______________ __________________ ___________________ ___________________

**Surgical History:**

| **Please list any surgeries from the last year** | **Date** |
| --- | --- |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

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In the last few weeks have you had problems with any of the following?

| | |
|---|---|
| Falls: | ( )Yes ( ) No |
| Fatigue: | ( )Yes ( ) No |
| Chest Pain: | ( )Yes ( ) No |
| Sortness of Breath: | ( )Yes ( ) No |
| Palpitations: | ( )Yes ( ) No |
| Leg Swelling: | ( )Yes ( ) No |
| Rash : | ( )Yes ( ) No |
| Nasal Congestion: | ( )Yes ( ) No |
| Sore Throat: | ( )Yes ( ) No |
| Hearing Loss: | ( )Yes ( ) No |
| Post Nasal Drip: | ( )Yes ( ) No |
| Dizziness: | ( )Yes ( ) No |
| Abdominal Pain: | ( )Yes ( ) No |
| Nausea: | ( )Yes ( ) No |
| Vomiting: | ( )Yes ( ) No |
| Heart Burn: | ( )Yes ( ) No |
| Indigestion: | ( )Yes ( ) No |
| Diarrhea: | ( )Yes ( ) No |
| Constipation: | ( )Yes ( ) No |
| Change in Bowel Habits: | ( )Yes ( ) No |
| Blood in Stool: | ( )Yes ( ) No |
| Hemorrhoids: | ( )Yes ( ) No |
| Bleeding Problems: | ( )Yes ( ) No |
| Clotting Problems: | ( )Yes ( ) No |
| Joint Pain: | ( )Yes ( ) No |
| Back Pain: | ( )Yes ( ) No |
| Headache: | ( )Yes ( ) No |
| Tingling/Numbness: | ( )Yes ( ) No |
| Sleep Problems: | ( )Yes ( ) No |
| Visual Changes: | ( )Yes ( ) No |
| Memory Loss: | ( )Yes ( ) No |
| Anxiety: | ( )Yes ( ) No |
| Sleep Disturbances: | ( )Yes ( ) No |
| Urinary Frequency: | ( )Yes ( ) No |
| Urinary Urgency: | ( )Yes ( ) No |
| Blood in Urine: | ( )Yes ( ) No |
| Urinary Incontinence: | ( )Yes ( ) No |
| Kidney Stones: | ( )Yes ( ) No |

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# Social History

Please answer the following questions.

What is your Marital Status? () Single () Married () Partnered () Divorced/ Separated () Widowed

How many people in household? () 1 () 2 () 3 () 4 ()5+

Highest education level? () High School () College () Graduate

Do you use recreational drugs? () Yes () No

Are there guns in your home? () Yes () No

Do you have a working smoke detector at home? () Yes () No

Do you exercise? () Never () Occasional () 1-2 Days a week () 3+ Days a week

Any questions about sex that you would like to discuss with the doctor? () Yes () No

Do you have regular eye care? () Yes () No

Do you have regular dental cleanings? () Yes () No

Are you on a special diet? () Yes () No

Have you've been a victim of abuse? () Yes () No

How is life in general? () Disastrous () Fair () Good () Very Good () Excellent

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# Burns Checklist ~ PHQ-9

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

(Use "x" to indicate your answer)

| | ~ 0 ~ Not at all | ~ 1 ~ Several days | ~ 2 ~ More than half the days | ~ 3 ~ 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 or feeling that you are a failure or that you have let yourself or your family down | | | | |
| 7) Trouble concentrating on things such as reading or watching TV | | | | |
| 8) Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual | | | | |
| 9) Thoughts that you would be better dead or that you want to hurt yourself in some way | | | | |

## Beck Index

| *How much you have been bothered by each symptom in the past week, including today....* | ~ 0 ~ None Not at all | ~ 1 ~ Mildly Didn't bother me much | ~ 2 ~ Moderately Unpleasent, but could stand it | ~ 3 ~ Severely Could barely stand it |
|---|---|---|---|---|
| Numbness or tingling | | | | |
| Feeling hot | | | | |
| Wobbliness in legs | | | | |
| Unable to relax | | | | |
| Fear of the worst happening | | | | |
| Dizzy or lightheaded | | | | |
| Heart pounding or racing | | | | |
| Unsteady | | | | |
| Terrified | | | | |
| Nervous | | | | |
| Feelings of choking | | | | |
| Hands trembling | | | | |
| Shaky | | | | |
| Fear of losing control | | | | |
| Difficulty breathing | | | | |
| Fear of dying | | | | |
| Scared | | | | |
| Indigestion or discomfort in abdomen | | | | |
| Faint | | | | |
| Face flushed | | | | |
| Sweating (not due to heat) | | | | |

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## The CAGE and CAGE-AID Questionnaire

| Question | Yes | No |
|---|---|---|
| Do you drink alcohol? | ◯ Yes | ◯ No |
| Have you ever experimented with drugs? | ◯ Yes | ◯ No |
| In the last three months, have you felt you should cut down or stop drinking or using drugs? | ◯ Yes | ◯ No |
| In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? | ◯ Yes | ◯ No |
| In the last three months, have you felt guilty or bad about how much you drink or use drugs? | ◯ Yes | ◯ No |
| In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs? | ◯ Yes | ◯ No |

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PATIENT NAME:_______________________________________DATE:____________

# Medicare Annual Wellness Visit Self-Assessment Form
## (For Medicare Patients Only Please)

**Please think about how you would answer the following questions based upon how you have been doing in the past four weeks Your answers will help you receive the best possible healthcare and allow us to identify areas in which we can help you best.**

| | **FALLS RISK** | | | |
|---|---|---|---|---|
| **1** | Have you fallen two or more times in the past year? | **YES** | **NO** | |
| | **If yes were you injured?** | **YES** | **NO** | |
| **2** | Do you have difficulty with dizziness or problems with balance? | **YES** | **NO** | |
| **3** | Do you avoid doing things due to the fear of falling? | **YES** | **NO** | |
| **4** | Do you have things in your house which might cause you to fall? | **YES** | **NO** | |
| | **PHYSICAL ACTIVITY AND PAIN** | | | |
| **1** | How often does physical/emotional health interfere with your daily activities? | **Frequently** | **Occasionally** | **Almost never** |
| **2** | How often do you take the escalator over the stairs? | **Frequently** | **Occasionally** | **Almost Never** |
| **3** | How often does pain interfere with your normal activities? | **Frequently** | **Occasionally** | **Almost never** |
| **4** | How much pain do you have on a daily basis? | **0 1 2 3 4 5 6 7 8 9 10** | | |
| | **If you do have daily pain, where is the pain located?** ______________________ | | | |
| **5** | Approximately how many days each week are you physically active? | **0-1 days** | **2-3 days** | **4 or more** |
| **6** | How many days a week do you exercise? | **0-1 days** | **2-3 days** | **4 or more** |
| **7** | How many hours of sleep do you usually get each night? | **5 or less hours** | **6-7 hours** | **8 or more hours** |
| | **ACTIVITIES OF DAILY LIVING** | | | |
| **1** | Can you eat, bathe, get dressed, get around your home without help? | **YES** | **NO** | |
| **2** | Are you able to prepare your own meals? | **YES** | **NO** | |
| **3** | Are you able to do your own housekeeping without help? | **YES** | **NO** | |
| **4** | Are you able to shop without help? | **YES** | **NO** | |
| **5** | Can you handle your own money without help? | **YES** | **NO** | |
| **6** | Are you able to travel independently by bus or taxi? | **YES** | **NO** | |
| **7** | Do you have enough help at home with your care or doing chores? | **YES** | **NO** | |
| **8** | Do you drive a car? | **YES** | **NO** | |
| | If yes: do you have any difficulty driving? | **None** | **Some Difficulty** | **Very Difficult** |
| | **OTHER HEALTH ISSUES** | | | |
| **1** | When was your last dilated eye exam? ____________________ | | | |
| | Name of your eye doctor:________________________________________ | | | |
| **2** | Do you have problems with your hearing? | **YES** | **NO** | |
| **3** | Do you have problems with your memory? | **YES** | **NO** | |
| **4** | Do you have trouble eating well? | **YES** | **NO** | |
| **5** | Do you have trouble with your teeth or dentures? | **YES** | **NO** | |
| **6** | Do you have a Living Will? | **YES** | **NO** | |
| | If yes, have you given us a copy? | **YES** | **NO** | |
| **7** | Did you get a flu shot this year? | **YES** | **NO** | |
| | If not do you want one? | **YES** | **NO** | |

PLEASE TURN PAGE

PATIENT NAME:_______________________________________
DATE:_________________

# Medicare Annual Wellness Visit Self-Assessment Form
## Page 2

**BLADDER CONTROL**

| # | Question | | | |
|---|---|---|---|---|
| 1 | Is leaking of urine a problem for you? | **YES** | **NO** | **N/A** |
| 2 | Has urine leakage changed your activities or interfered with sleep? | **YES** | **NO** | **N/A** |
| 3 | If urine leakage is a problem for you, would you be willing to try: | | | |
| | Medications | **YES** | **NO** | |
| | Bladder Training Exercises | **YES** | **NO** | |
| | Surgery | **YES** | **NO** | |

**MEDICATIONS**

***Remembering to take your medications can sometimes be challenging.***

| # | Question | | | |
|---|---|---|---|---|
| 1 | How often did you miss taking one or more of your medication in the last 2 weeks? | **Almost never** | **Occasionally** | **Frequently** |
| 2 | Are you unsure/confused about what your medications are for? | **YES** | **NO** | **N/A** |
| 3 | Are you unsure/confused about how or when to take your medications? | **YES** | **NO** | **N/A** |
| 4 | Are you unsure/confused about why you need to take your medications? | **YES** | **NO** | **N/A** |
| 5 | Do you have any medications your cannot afford? | **YES** | **NO** | **N/A** |
| 6 | Do you have trouble getting your medications due to the inability get to the pharmacy or the inability to have them delivered? | **YES** | **NO** | **N/A** |
| 7 | Do you have concerns/questions about your medication's side effects? | **YES** | **NO** | **N/A** |
| 8 | Do you have difficulty taking medicine the way you are instructed? | **YES** | **NO** | **N/A** |

**ISSUES EFFECTING YOUR HEALTH**

| # | Question | | | | |
|---|---|---|---|---|---|
| 1 | In the past year, was there a time when you couldn't afford to see a doctor? | **YES** | **NO** | | |
| 2 | Are you worried at times you cannot get your medicine due to expenses? | **YES** | **NO** | | |
| 3 | Do you ever eat less because there isn't enough food? | **YES** | **NO** | | |
| 4 | Are you worried that in the next few months you may not have housing? | **YES** | **NO** | | |
| 5 | Do you feel your safety is threatened in your home? | **YES** | **NO** | | |
| 6 | In the past year, have you had a hard time paying your utility bills? | **YES** | **NO** | | |
| 7 | Do you feel like it is a hardship to obtain household supplies? | **YES** | **NO** | | |
| 8 | Do you have any problems with access to transportation to get to your medical appointments? | **YES** | **NO** | | |
| 9 | Do you need a translator to communicate with your provider? | **YES** | **NO** | | |
| 10 | Do you have difficulty learning about your medical condition from the information given to you or what is told to you? | **YES** | **NO** | | |
| 11 | Do you miss having people around you? | **YES** | **NO** | | |
| 12 | Do you receive enough support from family and friends? | **ALWAYS** | **USUALLY** | **SOMETIMES** | **NEVER** |
| 13 | How confident are you that you can control and manage most of your health problems? | **VERY** | **SOMEWHAT** | **NOT VERY** | **N/A** |

**SATISFACTION WITH ACCESS**

| # | Question | | | | |
|---|---|---|---|---|---|
| 1 | In the past 12 months, how often did you get an appointment in the amount of time you felt was appropriate? | **ALWAYS** | **USUALLY** | **SOMETIMES** | **NEVER** |
| 2 | In the past 12 months, how satisfied are you with the care or treatment you received in this office? | **VERY** | **SOMEWHAT** | **NOT VERY** | **N/A** |

PLEASE TURN PAGE OVER

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# Medicare Preventative Services Recommendations

€ Mammogram every 1- 2 years for women until age 85

€ Glaucoma screening with your optometrist or ophthalmologist every 2 years

€ Vision screening as recommended by your eye care provider

€ Diabetes screening every year

€ Cholesterol screening at least every 5 years

€ Colonoscopy screening every 10 years until age 75 or more frequently as recommended

€ Influenza vaccine yearly

€ Shingles vaccine once after age 60 (This may or may not be covered by Medicare part D depending upon insurance coverage purchased by patient)

€ Pneumonia vaccine once after age 65 (This is covered by Medicare)

€ Tetanus /pertussis/diphtheria booster once after age 65 and every 10 years (This is NOT paid for by Medicare and is an additional cost to the patient)

€ DEXA scan screening for osteoporosis in women after age 65 and in high risk men after age 70

€ Stop Smoking

€ Decrease Alcohol

€ Exercise for 30 minutes or more 3 times a week

€ Lose Weight

€ Dietary Recommendations:
  - Make one half your plate fruits and vegetables
  - Make at least half your grains whole
  - Choose foods and drinks with little or no added sugars
  - Look out for salt (sodium) in foods you buy
  - Eat fewer foods that are high in saturated fats (animal fat, butter, cream, whole milk, stick margarine, coconut and palm oil
  - Eat the right amount of calories for you (get a personal daily calorie list at www.ChooseMyPlate.gov)
  - Use food labels to help make better food choices

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# Medicare Preventative Services Recommendations Con't

## HOME SAFETY

- In all living areas, avoid throw rugs and secure any loose carpet edges with nonskid tape.
- Make sure the floor is devoid of clutter and nightlights or motion-sensitive lighting are maintained throughout the home.
- Adding contrasting color strips to stairs aids in weakened depth perception and implementing grab bars and handrails helps with depreciated balance.
- Emergency numbers should be listed in large print by each phone. It's also smart to consider installing an electronic emergency response system, like LifeAlert.

## MEDICATION SAFETY

- Know the names of your medicines.
- Complete a Medication List and keep the list updated. Take it with you on each visit to your doctor or pharmacist, and whenever you travel away from home.
- Take your medicines until they're gone. This is especially important for antibiotics. If you are prescribed two weeks' worth of pills, don't stop them in a few days "because you're feeling better." These medicines need to be taken for the total duration of time that they are prescribed to completely clear the infection and keep it from coming back.
- Don't mix pills in bottles with other pills. Keep them in their original container (unless you place them in a dispenser).
- Be alert for any side effects, especially when starting a new medicine or increasing the dose of an existing medicine. Any new symptom in an older adult should be considered a medicine side effect until proved otherwise. Check with your doctor or pharmacist if you have any questions or suspect that your medicine may be causing problems.
- Use one pharmacy for all your prescription medicines. This will reduce the chance that you will obtain conflicting medicines from different pharmacies.
- Ask your pharmacist's advice before splitting or crushing any pills. Some pills should only be swallowed whole and may produce dangerous effects if the pill is altered.
- Keep all medicines out of the reach of children.
- Discard any medicines that you are no longer taking. Having old medicines around the house increases the risk that you or a family member might take them by accident, or that a child might get into them. Keep your medicines securely stored in a safe place.

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Dear Patients:
We are implementing two very important elements of our electronic health record program;
The Patient Portal and access to the Complete Prescription Medication History.

The Patient Portal section of our electronic record will:

1. Provide you access to important elements of your medical record including:
•Medical summaries
•Lab results
•Visit summaries

2. Facilitate secure email communications for non-urgent issues including
•Prescription refill requests
•Referral requests
•Appointment requests
•Non-urgent messages to and from your care team

***If you rarely check your email please DO NOT enable the portal.***

PLEASE NOTE: Response time for portal messages is 2 business days.
FOR URGENT ISSUES REQUIRING SAME DAY ATTENTION; PLEASE CALL THE OFFICE DIRECTLY.

**PATIENT PORTAL ACCESS REQUEST**

I request that NSIM provide me with access to the secure Patient Portal so that I can view portions of my medical record and send and receive non-urgent secure messages regarding my health records, laboratory tests, and appointments.

*If you do not wish to take advantage of this service, please check here.* ☐

**Print Email Address:** ______________________________

______________________________ ______________
**Print Patient Name** **DATE OF BIRTH**

______________________________ ______________
**Patient Signature** **Date**

The Complete Prescription Medication History section of our electronic record will:

- Have up-to-date information about all prescriptions given to you by all of your providers.
- Prevent adverse medication interactions.
- Our providers here at NSIM will be the only providers with access.

**CONSENT TO OBTAIN MY COMPLETE PRESCRIPTION MEDICATION HISTORY**

I authorize NSIM to view my external prescription history. My signature certifies that I have read and understand the scope of my consent and that I authorize access to my prescription medication history.

*If you do not wish to take advantage of this service, please check h*☐

______________________ ______________________ ______________
**Print Patient Name** **Patient Signature** **Date**

______________________ ______________________
**Witness** **Date**

**CONTACT PREFERNCES**

How would you prefer NSIM to contact you electronically for appointments reminders or to relay information?
(PLEASE CIRCLE ONLY ONE)

***HOME PHONE*** ***EMAIL*** ***TEXT MESSAGE*** ***CELL PHONE***

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# AUTHORIZATIONS
## ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.

I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance, and any other health plan to Ninth Street Internal Medicine Associates, Ltd.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

_______________________________________ ____________________________

**Signature of patient or responsible party** **Date**

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

## MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Ninth Street internal Medicine Associates Ltd for any services furnished me by Ninth Street Internal Medicine Associates, Ltd. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of related services.

_______________________________________ ____________________________

Medicare Beneficiary Signature Date

_______________________________________ ____________________________

Medicare Number Medigap Plan

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

In Compliance with Medicare regulation we are required to ask the following questions:

Do you or your spouse work for a company that provides you with health benefits? ☐Yes ☐No

Are you entitled to Medicare because of disability or End Stage Renal Disease? ☐Yes ☐No

Is the illness of injury the result of an automobile accident or other injury? ☐Yes ☐No

Has treatment for the accident or illness been authorized by the Veterans Administration? ☐Yes ☐No

Are you entitled to any benefits under the Federal Black Lung Program? ☐Yes ☐No

*I certify that this information is true and complete to the best of my knowledge*

Signature______________________________________ Date____________________

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# ACKNOWLEDGEMENT OF HEALTH INFORMATION PRACTICES

I, ________________________________________ acknowledge receiving a copy of the
Name
office's privacy notice. I have read it and I understand how my private health information will be used, and who will have access to it. I also understand that when the office discloses health information for any purpose outside of treatment, payment, and health care operations, it will require my signature in the form of a formal authorization.

**Please list the family members or other persons with whom we may discuss your general medical condition:**

________________________________ ________________________________
Name Relationship

________________________________ ________________________________
Name Relationship

Please list the additional family members or other persons with whom we may discuss your medical condition **ONLY IN AN EMERGENCY:**

________________________________ ________________________________
Name Relationship

________________________________ ________________________________
Name Relationship

Please indicate if you want all correspondence from this office sent to your home address
YES_______NO_______
Alternate address if not home:
_________________________________
_________________________________
_________________________________

Please indicate the telephone # you wish us to use to contact you __________________ May we leave a message on an answering machine/voice mail? YES_______NO_______

Date____________________ Signature _________________________________

*Please note: We are only allowed to communicate about you with individuals listed on this sheet, so please list all appropriate names and tell us if you need to update the list.*

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