Community Family Practice, PA

Welcome Home!

Thank you for choosing Community Family Practice as your Patient Centered Medical Home (PCMH). For more information about PCMH, please refer to the brochures around the office or ask any of the staff or providers.

We at Community Family Practice commend you on taking an active part in preventive medicine. As Benjamin Franklin once said, “An ounce of prevention is worth a pound of cure,” and we whole-heartedly agree. Many insurance companies are now providing one free preventative exam, or physical, every year. If you would like to discuss any chronic problems or new issues you may have during this visit, please be aware there may be an additional charge for this. The benefit is that you do not have to return to the clinic for a second visit, but the provider will bill for the portion of the visit that is not preventive medicine and a co-pay will be collected per your contract with the insurance company.

We will be collecting information to best care for you as a whole person, including: demographics; family, social and cultural characteristics; mental health and substance abuse history for you and your family; communication needs; behaviors that may affect your health or how health care is best delivered to you; and end of life decisions, and advanced directives. We will also be administering screenings for things such as depression, alcohol/ drug abuse, Alzheimer’s, and fall prevention. Of course, we will also be asking about changes to you and your family’s medical history, current medications including over-the-counter meds, allergies, trips to other health care professionals and trips to the hospital.

Another quote we really like at CFP, “Honesty is the best policy.” Please be honest when answering this questionnaire so your provider can offer the most appropriate resources to assist you with your lifestyle goals.

We will print a copy of your information at subsequent wellness visits for you to easily make changes. Thank you for completing this one by hand.

Name: _____ Date of Birth: _____

Current concerns: _____

_____

Current medications, dosages and how often taken (including over-the-counter meds):

_____

_____

Do you take your medications as prescribed? _____

Current Medication Allergies/ Medications you cannot take:

_____

Do you smoke cigarettes? _____

Do you drink alcohol? _____ If yes, please answer the following:

a. Have you ever felt you needed to cut down on your drinking? Yes No
b. Have people annoyed you by criticizing your drinking? Yes No
c. Have you ever felt guilty about drinking? Yes No
d. Have you ever felt you needed a drink first thing in the morning (eye opener,) to steady your nerves, or to get rid of a hangover? Yes No

Do you use illicit drugs? _____ If yes, please answer the following:

a. Have you ever felt you needed to cut down on your drug use? Yes No
b. Have people annoyed you by criticizing your drug use? Yes No
c. Have you ever felt bad or guilty about your drug use? Yes No
d. Have you ever used drugs first thing in the morning (eye opener,) to steady your nerves, or to get rid of a hangover? Yes No

List any risky or unhealthy behaviors that could affect your health (ie: poor nutrition, oral health, dental care, familial behaviors that have an effect on you or your health, sexual behaviors, etc)

_____

_____

Have you or a member of your family ever been diagnosed with a mental health/ behavioral condition? (ie: stress/ anxiety, depression, post-partum depression, ADD, ADHD, etc)
Please explain: _____

Currently or in the past, have you or any family member had an addiction to alcohol, prescription medications, illicit drugs?
Please explain: _____

Are there any outside factors to consider that may affect your health and well being? (ie: Poverty, homelessness, unemployment, lack of a support system, etc)
Please explain: _____

Are there any reasons that you would not be able to follow through with a plan of care that you and your doctor put together? (ie: financial difficulties, transportation issues, lack of health insurance, etc) Please explain: _____

What, if any, are some cultural, spiritual, or lifestyle beliefs that may impact the kind of healthcare you want to receive? _____

What, if any, traditional health remedies do you use at home to improve your health? _____

_____

Are you sexually active? _____

Do you identify as LBGT(lesbian, bisexual, gay or transgender)? _____

Do you exercise? _____What kind? : _____How often?_____

Have you fallen in the last year? _____

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
Little interest or pleasure in doing things you normally enjoy				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way other way				

What is your caffeine intake? _____

Please list all healthcare providers that you see or have seen other than those who are with CFP.

_____

_____

Please list all countries you travel to outside of the US.

_____

Is there a smoke detector in your house? _____

Is there a radon detector in your house? _____

Family History

	Alive or Deceased	Medical Diagnosis
Father		
Mother		
Brother		
Brother		
Sister		
Sister		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Other		
Other		

Immunization Dates:

Tetanus: _____ Pneumonia Vaccine: _____

Shingles Vaccine: _____ Flu Vaccine: _____

Review of Systems

Please circle any symptoms you may be experiencing or would like to discuss with the provider.

General: Fever Chills Sweats Weakness Fatigue Weight Loss Weight Gain

Cardiology: Irregular Heartbeat Passing out Chest pain Leg swelling

Dermatology: Skin lesion Rash New/Changing mole

Endocrinology: Excessive sweating Excessive urinating Excessive thirst Increased appetite
Cold Intolerance Heat Intolerance

Gastroenterology: Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in stool

Hematology: Swollen glands Easy bruising

Musculoskeletal: New/Worsening Joint pain New/ Worsening Back pain
Pain/Cramping in the lower leg Pain down the back of your leg

Neurology: Headache Numbness/Tingling Dizziness Memory loss
Unsteady/Abnormal walking

Ophthalmology: Blurred Vision Visual Changes

Psychology: Depression Anxiety Sleep disturbances

Respiratory: Shortness of breath Persistent cough Wheezing Coughing up blood

Urology: Painful urinating Blood in urine Urinary incontinence

Just for the males: Frequent night time urinating Obstructive symptoms when urinating

Just for the females: Vaginal bleeding abnormal vaginal discharge Pelvic pain
Pain with intercourse Nipple discharge Breast pain

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

_____

Marital Status: _____

Home Phone: _____Cell Phone: _____Work Phone:__ _____

Preferred Method of Contact for reminders: Text Message Telephone

Emergency contact name, phone number and relationship to patient:
_____

For children under 18 years old, Mother's maiden name: _____

Legal Guardian: _____

Preferred Pharmacy Local: _____ Mail in: _____

Race: American Indian/ Alaskan Native Asian Native Hawaiian/ Pacific Islander
Black/ African American White Hispanic
Other: _____ I do not wish to report

Ethnicity: Hispanic/ Latino Non/Hispanic/Latino I do not wish to report

Preferred Spoken Language: _____

If English is your second language and you find it at all difficult to understand your provider or you feel that your provider doesn't understand you, we highly encourage you to use a medically trained interpreter rather than a family member. We will provide the interpreter for you when you are being seen in the office. Do you need an interpreter to assist you in understanding the provider and to assist the provider in completely understanding you? _____

Occupation: _____ Place of Employment: _____

Are you disabled? _____

Do you have any Advanced Directives for end of life decisions? _____
Type: _____

Health Care Proxy (Power of Attorney): _____

Do you receive assistance with tasks of daily living or with managing your health? _____

Who is helping? _____ Relationship to patient: _____
Please make sure that the front office has a copy of your most current insurance card(s). Missing and incorrect insurance information could lead to your insurance company denying the claim and result in you being responsible for the entire balance. Remember that filing claims is time sensitive.