PRISM HEALTH

**PREVIOUS PROVIDER INFORMATION**

Are you transferring your care from another healthcare provider? ☐Y ☐N

If so, please list the name and phone number of your previous provider.
We will also ask you to fill out a Release of Information so we can obtain your medical records.
Name of Provider: _____
Phone Number: _____

**ALLERGIES**

List all medication, and other allergies (food, latex, etc.) you have as well as the reaction (hives, rash, swelling, etc.):

| Allergy | Reaction |
|---|---|
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**MEDICATIONS**

List all of your current medications and dosage. Include over-the-counter, vitamins, supplements, CPAP machines, allergy medications, and anything else you take:

| Medication Name | Dose | Frequency |
|---|---|---|
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**MEDICAL HISTORY**

Please check ALL that apply:

| | | | |
|---|---|---|---|
| ☐Abuse as Adult (victim) | ☐Cataracts | ☐Heart Murmur | ☐Osteoporosis |
| ☐Abuse as Child (victim) | ☐Clotting Disorder | ☐HIV/AIDS | ☐Seizures |
| ☐Allergies | ☐COPD | ☐Hyperlipidemia | ☐Sickle Cell Anemia |
| ☐Anemia | ☐Depression | ☐Hypertension | ☐Stomach Ulcers |
| ☐Anxiety | ☐Diabetes Mellitus | ☐Kidney Disease | ☐Stroke |
| ☐Arthritis/Joint Disorder | ☐GERD | ☐Liver Disease | ☐Substance Abuse |
| ☐Asthma | ☐Glaucoma | ☐Meningitis | ☐TB Disease |
| ☐Blood Transfusion | ☐Heart Disease | ☐Myocardial Infarction | ☐Thyroid Disease |
| ☐Cancer | ☐Heart Failure | ☐Nerve/Muscle Disease | |

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| REVIEW OF SYSTEMS<br>Please check ALL that apply and have occurred within the last three months, and lasting several days: | | | | |
|---|---|---|---|---|
| BLOOD | ☐Anemia | ☐Clots | ☐Fatigue | ☐Bleeding Issues |
| CARDIOVASCULAR | ☐Chest Pain | ☐Feet/Leg Swelling | ☐Fainting | ☐Palpitations |
| GASTROINTESTINAL | ☐Nausea/Vomiting | ☐Constipation | ☐Diarrhea | ☐Heartburn |
| GLANDS/HORMONES | ☐Cold Intolerance | ☐Heat Intolerance | ☐Menopause | ☐Menstrual Issues |
| MENTAL HEALTH | ☐Anxiety | ☐Depression | ☐Hallucinations | ☐Suicidal Ideations |
| MUSCULOSKELETAL | ☐Pain | ☐Stiffness | ☐Swelling | ☐Weakness |
| NEUROLOGICAL | ☐Weakness | ☐Headaches | ☐Neck/Back Pain | ☐Limb Numbness |
| OB/GYNECOLOGICAL | ☐Burning | ☐Cramps | ☐Pregnancy | ☐Itching |
| RENAL | ☐Kidney Stones | ☐Urgency/Pain | ☐Blood in Urine | ☐Incontinence |
| RESPIRATORY | ☐Cough | ☐Shortness of Breath | ☐Wheezing | ☐Wet cough |
| SKIN | ☐Bruising | ☐Burns | ☐Itching/Rash | ☐Wounds |

| SURGICAL HISTORY<br>List all surgeries you have had and the date of the surgery: | |
|---|---|
| Surgery | Date |
| | |
| | |
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| | |

| FAMILY HISTORY<br>Please list any illnesses, diseases, and/or conditions that any of your immediate family members has had: | |
|---|---|
| Family Member | Illness / Disease / Condition |
| | |
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| | |
| | |

| SOCIAL HISTORY | |
|---|---|
| Do you smoke tobacco products?☐Yes ☐Not Currently ☐ Never<br>What do you smoke? _____<br>How many packs per day? _____<br>Start date:_____Quit date: _____ | Do you chew tobacco? ☐Y ☐N<br>Start date:_____Quit date: _____<br>Would you like to discuss quitting tobacco products?<br>☐Y ☐N |
| Do you drink alcohol? ☐Yes ☐Not Currently ☐Never<br>What do you drink? ☐ Beer ☐ Wine ☐ Liquor | How many drinks per week? _____ |
| Substance Use: ☐Yes ☐Not Currently ☐ Never<br><br>Comments: _____ | ☐Vaping ☐Marijuana ☐Opioids ☐Heroin<br>☐Methamphetamine ☐Amphetamines ☐PCP<br>☐Ecstasy ☐LSD ☐Ketamine ☐Mescaline ☐Psilocybin<br>☐Cocaine ☐Crack ☐Nitrous Oxide ☐Solvent Inhalants<br>☐Barbiturates ☐Benzodiazepines ☐IV ☐other |

Patient Name:_____DOB: _____

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| SEXUAL ACTIVITY | |
|---|---|
| Sexually Active: ☐Yes ☐Not Currently ☐Never | |
| Birth Control / Protection:<br>☐Abstinence ☐Cervical Cap ☐Condom ☐Diaphragm ☐Fertility Awareness ☐Hormonal Patch<br>☐Implant ☐Injection ☐Inserts ☐IUD ☐Menopause ☐None ☐Pill ☐Rhythm ☐Spermicide ☐Sponge ☐Surgical<br>☐Vaginal Ring ☐Vasectomy ☐Withdrawal | |
| Partners:<br>☐Female ☐Male ☐ Transgender Female ☐Transgender Male ☐Other ☐Choose not to disclose<br>☐Non-binary/Gender Fluid ☐Questioning<br>Comments: _____ | |
| Has there been any change to your sexual desire?<br>☐Y ☐N | If yes, please describe the change: |
| Have you had vaginal or anal sex with someone living with HIV? ☐Y ☐N ☐Not sure | Have you had vaginal or anal sex with someone that uses injection drugs? ☐Y ☐N ☐Not sure |
| Please answer this question *only* if you identify as female: Have you had vaginal or anal sex with someone that has a penis and that person also has sex with people that have a penis? ☐Y ☐N | Have you ever exchanged sex for something you need?<br>☐ Yes ☐ No |
| Have you ever had an STD/STI?<br>☐Y ☐N | If yes, please check all that apply:<br>☐Gonorrhea ☐Chlamydia ☐Herpes ☐Syphilis ☐HPV ☐HIV<br>☐Another _____ |
| Have you ever been tested for HIV? ☐Y ☐N | Would you like to be tested for HIV? ☐Y ☐N |
| Are you trying to become pregnant? ☐Y ☐N ☐N/A | Do you have pain during intercourse? ☐Y ☐N ☐Sometimes |
| Do you have any questions or concerns about your sexual health? □ Yes □No<br>If yes, please explain: | |

| RELATIONSHIP SAFETY SCREENING | |
|---|---|
| How often does anyone, including family and friends, physically hurt you? | ☐Never ☐Rarely ☐Sometimes ☐Fairly Often ☐Frequently |
| How often does anyone, including family and friends, insult or talk down to you? | ☐Never ☐Rarely ☐Sometimes ☐Fairly Often ☐Frequently |
| How often does anyone, including family and friends, threaten you with harm? | ☐Never ☐Rarely ☐Sometimes ☐Fairly Often ☐Frequently |
| How often does anyone, including family and friends, scream or curse at you? | ☐Never ☐Rarely ☐Sometimes ☐Fairly Often ☐Frequently |

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| **PHQ – 9** | |
|---|---|
| Over the last two weeks, how often have the following issues applied to you? | |
| Little interest or pleasure in doing things | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Feeling down, hopeless, depressed | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Trouble falling/staying asleep, sleeping too much | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Feeling tired or having little energy | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Poor appetite or overeating | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Feeling badly about yourself | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Trouble concentrating at work or school | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Moving/speaking slowly, or being fidgety/restless | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Thoughts of suicide, or hurting yourself | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| If you checked off any of the above problems, how difficult have these problems made it for to do your work, take care of your home, or get along with other people? | ☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult |
| **GAD – 7** | |
| Over the last two weeks, how often have you been bothered by the following problems? | |
| Feeling nervous, anxious or on edge | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Not being able to stop or control worrying | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Worrying too much about different things | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Trouble relaxing | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Being so restless that it is hard to sit still | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Becoming easily annoyed or irritable | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| Feeling afraid as if something awful might happen | ☐Not at all ☐Several days ☐More than half the days ☐ Nearly every day |
| If you checked off any of the above problems, how difficult have these problems made it for to do your work, take care of your home, or get along with other people? | ☐Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐Extremely difficult |

Patient Name:_____DOB: _____

| **ALCOHOL USE QUESTIONNAIRE**<br>Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below. Let your provider know if you have any questions.<br>*One drink = 12 oz. beer / 5 oz. wine / 1.5 oz. liquor (one shot)* | |
|---|---|
| How often do you have a drink containing alcohol? | ☐ Never ☐Monthly or less ☐2 - 4 times a month ☐2 - 3 times a week<br>☐4 or more times a week |
| How many drinks containing alcohol do you have on a typical day when you are drinking? | ☐ 0 – 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 - 9 ☐ 10 or more |
| How often do you have four or more drinks on one occasion? | ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily |
| How often during the last year have you found that you were not able to stop drinking once you had started? | ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily |
| How often during the last year have you failed to do what was normally expected of you because of drinking? | ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily |
| How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily |
| How often during the last year have you been unable to remember what happened the night before because of your drinking? | ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily |
| Have you or someone else been injured because of your drinking? | ☐ No ☐ Yes, but not in the last year ☐Yes, in the last year |
| Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | ☐ No ☐ Yes, but not in the last year ☐Yes, in the last year |

Patient Name:_____DOB: _____

**DRUG USE QUESTIONNAIRE**

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

Please mark all substances that you have used in the last 12 months:

☐ Methamphetamines (speed, crystal, etc.) ☐ Cocaine ☐ Marijuana ☐ Narcotics (heroin, oxycodone, etc.)
☐ Inhalants (aerosol, glue, etc.) ☐ Hallucinogens (LSD, mushrooms, etc.) ☐ Tranquilizers (Valium, Xanax, etc.)
☐ Other _____

| | |
|---|---|
| How often have you used these drugs? | ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily |
| Have you used drugs other than those required for medical reasons? | ☐ No ☐ Yes |
| Do you use more than one drug at a time? | ☐ No ☐ Yes |
| Are you unable to stop using drugs when you want to? | ☐ No ☐ Yes |
| Have you ever had blackouts or flashbacks as a result of drug use? | ☐ No ☐ Yes |
| Do you ever feel bad or guilty about your drug use? | ☐ No ☐ Yes |
| Do your family, partner, and/or friends ever complain about your involvement with drugs? | ☐ No ☐ Yes |
| Have you neglected your family because of your use of drugs? | ☐ No ☐ Yes |
| Have you engaged in illegal activities in order to obtain drugs? | ☐ No ☐ Yes |
| Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | ☐ No ☐ Yes |
| Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions)? | ☐ No ☐ Yes |

Patient Name:_____DOB: _____

PRISM HEALTH

| **OTHER**<br>Is there anything else you would like your medical provider to know about you? |
| --- |
| |

Please read this following carefully and sign below:

I certify that the information I have given on my patient intake form is correct and complete to the best of my knowledge. I acknowledge that keeping any health information from my provider may hinder them from being able to give me adequate patient care. It is my responsibility to keep my provider informed of any new health issues that may arise.

_____ _____

Patient Signature Date

Patient Name:_____ DOB: _____