DESERET FAMILY MEDICINE NP PATIENT DEMOGRAPHIC FORM - PLEASE PRINT

TODAY'S DATE:_____

PATIENT NAME: _____

SEX: □ MALE □ FEMALE **DATE OF BIRTH**: _____ **AGE**: _____ **SOCIAL SECURITY #**:_____

RELATIONSHIP TO PT.: □ SELF □ SPOUSE □ CHILD □ OTHER

IS PATIENT: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

LOCAL ADDRESS:_____ **CITY, STATE, ZIP**:_____

SUMMER ADDRESS:_____**CITY, STATE, ZIP**:_____

HOME PHONE:_____ **WORK PHONE**: _____ **CELL PHONE**:_____

EMAIL ADDRESS:_____ **PREFERRED METHOD OF CONTACT**: _____

PRIMARY LANGUAGE:_____ **RACE/ETHNICITY**: _____

EMERGENCY CONTACT NAME/RELATIONSHIP:_____

EMERGENCY CONTACT PHONE NUMBER (MUST BE DIFFERENT THAN YOUR PHONE #):_____

PREFERRED PHARMACY NAME AND CROSS STREETS/PHONE #:_____

IS YOUR SPOUSE/PARENT EMPLOYED? ____YES ____NO **ARE YOU ON THEIR POLICY?** ____YES ____NO

ARE YOUR INJURIES WORK RELATED OR ACCIDENT RELATED? ____YES ____NO

DO YOU HAVE A MEDICAL MARIJUANA CARD? ____ YES ___ NO (If yes, please provide a copy to the front desk)

DO YOU HAVE A PRESCRIPTION (RX) CARD? ____ YES ___ NO (If yes, please provide a copy to the front desk)

WHO OVER THE AGE OF 18 IS RESPONSIBLE FOR THIS BILL? _____ PHONE: _____

INSURANCE INFORMATION:

MUST FILL IN ALL INFORMATION	**MUST FILL IN ALL INFORMATION**
PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
INS. CO. ADDRESS:_____	INS. CO. ADDRESS:_____
POLICY HOLDER NAME:_____	POLICY HOLDER NAME: _____
EMPLOYER:_____	EMPLOYER:_____
POLICY NO:_____GROUP/CLAIM NO:_____	POLICY NO:_____GROUP CLAIM NO:_____
EFFECTIVE DATE:_____	EFFECTIVE DATE:_____
POLICY HOLDER SEX: □F □ M BIRTHDATE:_____	POLICY HOLDER SEX □ F □ M BIRTHDATE:_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

SIGNED (Patient or legal guardian): _____ **Date**: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

DESERET FAMILY MEDICINE
7165 East University Drive, Ste. 141
Mesa, Arizona 85207

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I also, acknowledge receipt and have read and understand the *Notice of Health Information* Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Patient Name (printed): _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ **DOB**:_____

DATE:_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?
(use " √ " to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping to much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all _____ Somewhat difficult ____ Very difficult _____ Extremely difficult ____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring care)

Add columns: _____ + _____ + _____ + _____

= Total Score: _____

FALLS SCREENING TEST

Patient Name: _____ **DOB:** _____

DATE: _____

PART ONE: Questionnaire

1. How many times in the past year did you fall?

   0 or 1 fall = score 0
   2 or more falls = score 1 Score: _____
   1a. Have you injured yourself from any falls?
   No injury or no fall = score 0
   Any injury (soft tissue, fracture) = score 1 Score: _____

1. How often does it happen to you that you think you are about to fall but manage to grab something and then don't fall?

   Never or rarely have "near falls" = score 0
   Occasionally or frequently have "near falls" = score 1 Score: _____

Total Score:_____

In office use below:

If Total Score is 2 or greater, administer Multi-Factor Falls Assessment below.
Respondent is asked to walk at normal pacing speed over a 10 feet distance.

Walking speed is recorded with stopwatch.

If walking speed is faster than 10 seconds over 10 ft = Score of 0
If walking speed is slower than 10 seconds over 10ft = Score of 1 Score: _____

Gait style is observed and recorded

If gait is even, straight and feet are raised with each step = Score of 0
If gait is uneven, shuffling, on a wide base, or unsteady = Score of 1 Score: _____

Patient Name: _____ **DOB:** _____

Family History-Has any blood relative had any of the following? Please indicate relationship.

No significant family history	_____		
Adopted, doesn't know family history	_____	Heart Attack	_____
Adverse reaction to anesthesia	_____	Heart Disease	_____
Alcoholism	_____	HIV Infection	_____
Allergies	_____	Hypertension	_____
Alzheimer's	_____	Kidney Disease	_____
Anxiety Disorder	_____	Liver Disease	_____
Arthritis	_____	Lung Disease	_____
Asthma	_____	Mental Disorder	_____
Bleeding Problems	_____	Migraine Headache	_____
Cancer (specify type)	_____	Seizure Disorder	_____
Depression	_____	Stroke	_____
Diabetes Mellitus	_____	Thyroid Disorders	_____

Other, please specify: _____

Are you sexually active: ❑ No ❑ Yes

If yes, do you use safe sex methods (such as condoms) to prevent sexually transmitted diseases? ❑ No ❑ Yes

Pregnancy:

Total pregnancy # _____	Full Term # _____	Premature # _____
Terminated # _____	Miscarriages # _____	Ectopic # _____
Multiple # _____	Living # _____	

Menstrual History:

Age of 1st period: _____ Flow: ☐ Light ☐ Medium ☐ Heavy

Last Period: _____ Method of Birth Control: _____

Menopause Status: _____ Age Menopause: _____

Patient Name: _____ **DOB**: _____

Medical History: Please list all serious illnesses, operations and hospitalizations you have experienced and indicate the date they occurred.

No significant medical history: _____

Illness/Operation:

_____
_____
_____

Date of Illness/Operation:

_____
_____
_____

Past Medical History-Please check any that apply to you.

__ Allergies
__ Anemia
__ Anxiety
__ Arthritis
__ Asthma
__ Cancer
__ Chronic pain
__ Depression
__ Diabetes
__ Elevated cholesterol
__ Erectile dysfunction/libido issues
__ Eye disease (glaucoma, cataracts)
__ Gastrointestinal issues
__ Heart disease
__ Hepatitis A, B or C
__ Hypertension
__ Insomnia/sleep disorder
__ Kidney disease
__ Migraines
__ Psychological disorder
__ Seizure disorder
__ Stroke
__ Thyroid disorder
__ Urinary disorder
__ Other problem/s not listed here: _____

Are you experiencing any of the following?

__ Appetite changes
__ Breast pain/symptoms/lumps
__ Chest pain/palpitations/shortness of breath
__ Confusion or other cognitive changes
__ Cough or other lung symptoms
__ Difficulty swallowing
__ Feeling tired or poorly
__ Fever/chills
__ GI symptoms (heartburn, nausea, diarrhea, vomiting)
__ Headaches
__ Joint or muscle pain/stiffness
__ Libido (sexual) changes
__ Mood/psychological changes (depression, anxiety)
__ Neurological problems (seizures, numbness, weakness, tingling)
__ Rashes or other skin changes
__ Sleep changes
__ Urinary changes
__ Weakness
__ Weight change
Other symptoms you are experiencing that are not listed here:
_____

Patient Name: _____ **DOB:** _____

Social History:

Tobacco: ❑ Never ❑ Yes (___packs/day x ___ yrs) ❑ Quit ___years ago (___packs/day x ___ yrs)

Alcohol: ❑ Never ❑ Socially ❑ Less than 10 drinks per week ❑ More than 10 drinks per week

Recreational Drug Use: ❑ No ❑ Yes Which type: _____

Marital Status: ❑ Single ❑Engaged ❑ Married ❑ Widowed ❑ Divorced ❑ Partner

Lives: ❑ Alone ❑ With Parents ❑ With Spouse ❑ Assisted Living Facility ❑ Nursing Home

Occupation: _____ Retired: _____ Student: _____

Do you follow a special diet: ❑ Yes ❑ No Explain: _____

Do you exercise? ❑ Yes ❑ No How often: _____ Do you use seat belts? _____

Do you have a living will and/or power of attorney: ❑ Yes (please provide a copy to the front desk) ❑ No

Medications: Please list all medicines you are currently taking ___Patient denies taking any Medications

CURRENT MEDICATIONS :	DOSAGE:	FREQUENCY:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please List all ALLERGIES (food, drugs, environment):

_____ _____

_____ _____

_____ _____

Flowsheet: Please indicate the last time you had the following done.

Annual Physical Exam: _____ Pap Smear: _____ Mammogram: _____ Colon Cancer Screening: _____

Tetanus: _____ Flu Vaccine: _____ Shingles Vaccine: _____ Pneumonia Vaccine: _____

COVID Vaccine: _____ Glaucoma Screening: _____ DEXA Scan:_____

PATIENT SIGNATURE: _____ **DATE:** _____