



PATIENT INFORMATION SHEET

Last Name _____ First Name _____ MI _____

SSN# _____ - _____ - _____ DOB ____/____/____ Age _____

Address _____ City _____ State _____ Zip _____

Phone #1 (____) _____ ☐ Home ☐ Cell ☐ Work Phone #2 (____) _____ ☐ Home ☐ Cell ☐ Work

Email _____ Preferred method of appt. reminder: ☐ Text ☐ Email

Referred By: _____

Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Race: ☐ White ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Other _____

Ethnicity: ☐ Hispanic-Latino ☐ Non-Hispanic-Latino Language: ☐ English ☐ Spanish ☐ Other _____

Country of Origin: ☐ USA ☐ Other _____

Employment Status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Employer: _____ Occupation: _____

Emergency Contact _____ Relationship: _____

Address _____

Phone (____) _____ Cellular (____) _____

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

Pharmacy (Local): _____ City _____ Phone # (____) _____

Pharmacy Name (Mail Order): _____ Phone # (____) _____

Do you have a Living Will? ☐ YES ☐ NO (If so, please provide us with a copy for your medical chart.)

I hereby authorize LifeWay, Inc. and/or its staff and affiliates to render medical treatment to me as necessary. I fully understand that I am ultimately responsible for payment for all services provided to me and request that payment from my insurance carrier be made directly to LifeWay, Inc. I also understand that by signing below, my insurance carrier has full access to my entire medical records that may include sensitive, personal and confidential information.

Patient's Signature

Date



PATIENT MEDICAL HISTORY FORM

Today's Date: ____/____/____

Name: _____ DOB: ____/____/____ Age: ____

Reason for Visit: _____

Last WELL/PHYSICAL Exam: ☐ Less than 1 year ☐ Greater than 1 year (Date: _____)

DRUG ALLERGIES:	FAMILY HISTORY						
	<i>(Indicate if deceased)</i>	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
	Heart Disease						
	High Blood Pressure						
	Stroke						
	Cancer						
	Glaucoma						
	Diabetes						
	Epilepsy/Convulsions						
	Bleeding Disorder						
	Kidney Disease						
	Thyroid Disease						
	Mental Illness						
	Osteoporosis						

HOSPITALIZATIONS OR SURGERIES			
REASON	DATE	REASON	DATE

MEDICAL HISTORY			
☐ ADD/ADHD	☐ Depression	☐ Hepatitis (☐ A ☐ B ☐ C)	☐ Pneumonia
☐ Allergies	☐ Diabetes	☐ Hernia	☐ Prostate disease/BPH
☐ Anemia	☐ Epilepsy	☐ Herpes	☐ Sexual dysfunction
☐ Anxiety	☐ Gallbladder disease	☐ HIV (Date _____)(State____)	☐ Sinus issues
☐ Arthritis/Joint pain	☐ GI disorder/Acid reflux	☐ Hypertension	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Insomnia	☐ Syphilis
☐ Bipolar disorder	☐ Gout	☐ Kidney disease	☐ Thyroid disease
☐ Bowel irregularity	☐ Headache/Migraine	☐ Neuropathy	☐ Ulcer
☐ Cancer	☐ Heart disease/MI	☐ Osteoporosis	☐ Vascular disease/PVD
☐ Cholesterol high	☐ Heart murmur	☐ Pain chronic _____	☐ Other _____

IMMUNIZATIONS	HABITS	TESTS AND SCREENINGS
COVID vaccine: ____ ____ ____	☐ Smoker _____ packs daily	Colonoscopy: ____ ____ ____
Flu vaccine: ____ ____ ____	☐ Former smoker	Pap Smear: ____ ____ ____
Pneumonia vacc: ____ ____ ____	☐ Never smoked	Mammogram: ____ ____ ____
Tetanus vaccine: ____ ____ ____	☐ Alcohol: Beer Wine Liquor	Bone density: ____ ____ ____
Hepatitis A: ____ ____ ____	☐ Frequency: # _____ Day Week	Eye exam: ____ ____ ____
Hepatitis B: ____ ____ ____	☐ No alcohol consumption	



HEALTH RISK ASSESSMENT

PHYSICAL ACTIVITY

- How many days per week do you exercise?
☐ 3 or more ☐ 3 or less ☐ Currently not exercising
- How intense is your typical exercise?
 - ☐ Light (stretching, slow walking)
 - ☐ Moderate (brisk walking)
 - ☐ Heavy (jogging, swimming)
 - ☐ Very heavy (fast running, stair climbing)

TOBACCO USE

- Tobacco Status:
 - ☐ Never used tobacco (*Skip to next section*)
 - ☐ Former tobacco user
 - When did you quit? _____
 - ☐ Current tobacco user
 - When did you start? _____
 - ☐ Cigarettes ☐ Cigars ☐ Vape ☐ Chew
- Tobacco Daily Usage (*also if former smoker*):
 - ☐ < ½ pack ☐ 1 pack ☐ > 1 pack ☐ 2 packs ☐ > 2 packs
 - ☐ Other: _____

ALCOHOL USE

- Alcohol Intake:
 - ☐ No alcohol consumption (*Skip to next section*)
 - ☐ Beer _____ ☐ Wine _____ ☐ Liquor _____ (# per occasion)
- Alcohol Frequency:
 - ☐ Socially ☐ Once a week ☐ 2-3 week ☐ >3 week ☐ Daily

ILLICIT DRUG USE

- Illegal drug use and/or Prescription drug abuse:
 - ☐ No drug use or abuse (*Skip to next section*)
 - ☐ History of: When did you stop? _____
 - ☐ Current use: When did you start? _____
 - ☐ Name of drugs _____

SLEEP HABITS

- How many hours of sleep do you get each night?
 - ☐ < 3 hrs ☐ 4-5 ☐ 6-7 ☐ 8-9 ☐ 10-11 ☐ > 12 hrs
- Do you snore or has anyone told you that you snore?
 - ☐ Yes ☐ No
- Do you feel sleepy during the daytime?
 - ☐ Always ☐ Often ☐ Sometimes ☐ Rarely

RELATIONSHIP

- Are you currently married or in a relationship with a significant other?
 - ☐ Yes
 - ☐ No

ABUSE

- Has anyone hurt or abused you in the last year?
 - ☐ Yes (☐ Physical ☐ Sexual ☐ Mental)
 - ☐ No

SEXUAL HEALTH

- How many sexual partners have you had in past year?
 - ☐ Not sexually active ☐ 1 partner ☐ 2 or more
- Are your sexual partners:
 - ☐ Male ☐ Female ☐ Both
- Do you use protection against sexually transmitted diseases? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely

NUTRITION

- Fruits and vegetables:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot
- High fiber or whole grain:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot
- Fried or high-fat food:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot
- Sugar:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot
- Caffeine:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot

GENERAL HEALTH

- In general, would you say your health is:
 - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
- How would you describe your mouth and teeth?
 - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
- How would you describe your hearing?
 - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
- How would you describe your vision?
 - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

ADVANCE CARE PLANNING

- Which of the following do you have?
(Please provide a copy to us for your medical record.)
 - ☐ Living Will ☐ Health Surrogate ☐ Power of Attorney
 - ☐ Do Not Resuscitate ☐ None



HEALTH RISK ASSESSMENT

(Age 64+)

ACTIVITIES OF DAILY LIVING

In the past 7 days, did you need help from others to perform everyday activities such as: ☐ Yes ☐ No

Basic Activities of Daily Living (ADLs)

- ☐ Eating
- ☐ Dressing
- ☐ Grooming
- ☐ Bathing
- ☐ Walking
- ☐ Toileting

Instrumental Activities of Daily Living (IADLs)

- ☐ Laundry
- ☐ Housekeeping
- ☐ Shopping
- ☐ Food preparation
- ☐ Transportation
- ☐ Managing finances
- ☐ Managing medications

COGNITIVE SCREENING

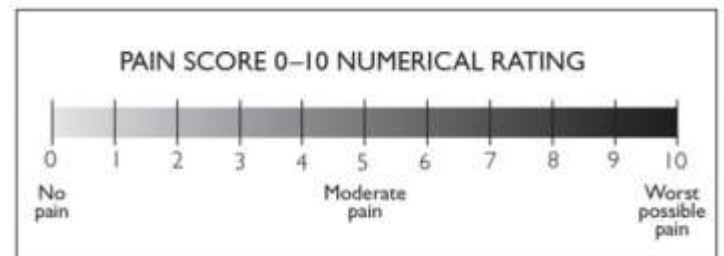
1. Do you have forgetfulness or memory loss?
☐ Yes ☐ No
2. Do you forget important events/appointments?
☐ Yes ☐ No
3. Do you lose your train of thought?
☐ Yes ☐ No
4. Are you overwhelmed by tasks or instructions?
☐ Yes ☐ No
5. Do you have trouble navigating around familiar environments?
☐ Yes ☐ No
6. Are you more impulsive or have increasingly poor judgment? ☐ Yes ☐ No
7. Have family and friends noticed these changes?
☐ Yes ☐ No

FALL RISK ASSESSMENT

1. How many times have you fallen in the past year?
☐ None ☐ Once ☐ Twice ☐ Three or more
2. Have you lost balance causing you to stumble or trip?
☐ Yes ☐ No
3. Do you feel unsteady when standing or walking?
☐ Yes ☐ No
4. Are you worried about falling?
☐ Yes ☐ No

PAIN ASSESSMENT

1. Do you experience chronic pain?
☐ Yes ☐ No
2. In what body area(s) do you experience pain?
☐ Back ☐ Neck ☐ Knees ☐ Hips ☐ Shoulders
☐ Arms ☐ Legs ☐ Hands ☐ Feet ☐ Multiple joints
☐ Other _____
3. If yes, what is your average daily pain intensity?



4. Aggravating Factors: What makes your pain worse?
☐ Sitting ☐ Standing ☐ Bending ☐ Lying down
☐ Other _____
5. Alleviating Factors: What makes your pain better?
☐ Heat ☐ Cold ☐ Massage ☐ Medication
☐ Other _____

DEPRESSION ASSESSMENT PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

	+		+	
--	---	--	---	--

(Healthcare professional: For interpretation of TOTAL, TOTAL: _____
please refer to accompanying scoring card).

10. 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 difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

LifeWay, Inc.

American Urological Association Urinary/BPH Symptom Score Index Questionnaire

Name _____ Date _____

Please fill out this short questionnaire to help us find out more about any urinary problems you might have; for questions 1 through 7, circle the number under the column that best describes your situation; for question 6, circle the number in the row which best describes your situation.

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always
1. INCOMPLETE EMPTYING: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. FREQUENCY: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
2. INTERMITTENCY: Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
3. URGE TO URINATE: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING: Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5+ times
7. URINATING AT NIGHT: Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

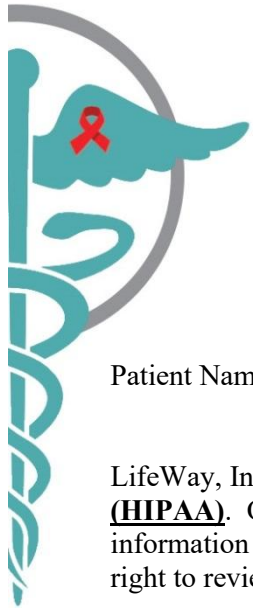
Symptom Score:

1-7 Mild, 8-19 Moderate, 20-35 Severe

Total: _____

BOTHERSOME SCORE DUE TO URINARY SYMPTOMS

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
QUALITY OF LIFE DUE TO URINARY SYMPTOMS: How would you feel if you had to live with your urinary condition the way it is now – no better, no worse – for the rest of your life?	0	1	2	3	4	5	6



Notice of Privacy Practices Consent Form

Patient Name: _____ Date of Birth: _____

LifeWay, Inc. is providing this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

Listed below are the individuals to whom I give permission to LifeWay, Inc., its physicians, staff members and/or representatives, to review and discuss my medical and/or financial issues:

1) Name: _____ DOB: ____/____/____ ☐ Medical ☐ Financial
Phone: (____) _____ Alt. Phone: (____) _____
Relationship: ☐ Spouse ☐ Partner ☐ Mother ☐ Father ☐ Adult Child ☐ Sibling ☐ Other _____

2) Name: _____ DOB: ____/____/____ ☐ Medical ☐ Financial
Phone: (____) _____ Alt. Phone: (____) _____
Relationship: ☐ Spouse ☐ Partner ☐ Mother ☐ Father ☐ Adult Child ☐ Sibling ☐ Other _____

3) Name: _____ DOB: ____/____/____ ☐ Medical ☐ Financial
Phone: (____) _____ Alt. Phone: (____) _____
Relationship: ☐ Spouse ☐ Partner ☐ Mother ☐ Father ☐ Adult Child ☐ Sibling ☐ Other _____

By signing below, I acknowledge that I have read and understand the Patient Privacy Notice from LifeWay, Inc. and consent to the release of information as I have specified above.

Patient's Signature

Date

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