

North Country Adult Medicine

Patient Name: _____

DOB: _____

Please check off any symptoms you have had in the past year:

- | | | |
|--|--|--|
| ☐ No symptoms | ☐ Chest Pain or Pressure | ☐ Urinary Frequency/Urgency |
| ☐ Dizziness | ☐ Irregular Heart beat | ☐ Urine Accidents |
| ☐ Fatigue | ☐ Near fainting/passing out | ☐ Weak Urine Stream |
| ☐ Weight loss | ☐ Short of breath on exertion | ☐ Headache |
| ☐ Itchy Eyes | ☐ Swelling of ankles/legs | ☐ Memory Loss |
| ☐ Runny Nose | ☐ Abdominal Pain | ☐ Tingling/Numbness |
| ☐ Hoarseness | ☐ Blood in the Stool | ☐ Tremor |
| ☐ Snoring | ☐ Constipation | ☐ Anxiety |
| ☐ Blurring of Vision | ☐ Chronic Diarrhea | ☐ Depression |
| ☐ Double Vision | ☐ Difficulty Swallowing | ☐ Mood Swings |
| ☐ Excessive Sweating | ☐ Untreated Heartburn | ☐ Breast lumps |
| ☐ Excessive Thirst | ☐ Easy Bleeding or Bruising | ☐ Nipple Discharge |
| ☐ Cough | ☐ Swollen glands/lymph nodes | ☐ Difficulty with Erection |
| ☐ Shortness of Breath | ☐ Joint Pain | ☐ Testicular Lump |
| ☐ Coughing up blood | ☐ Muscle Aches | |
| ☐ Leg Pain with walking | ☐ Abnormal Moles | |

SPECIALISTS / OTHER CLINICIANS

List specialists you currently see. Include medications they prescribe so we know which clinician is responsible for those prescriptions.

Specialty	Provider Name	Reason You See Them	Medications They Prescribe

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SOCIAL HEALTH

Tobacco & Vaping

Cigarettes: ☐ Never ☐ Current ☐ Former Age started: ____ Packs/day: ____ Age quit: ____

Other tobacco: ☐ Cigars ☐ Chewing tobacco ☐ Other: _____

Current vaping: ☐ Yes ☐ No What do you vape? _____

Marijuana & Caffeine

Current marijuana use: ☐ Yes ☐ No Method: ☐ Smoked ☐ Vaped ☐ Edible ☐ Tincture ☐ Other: _____

Typical marijuana frequency/amount: _____

Caffeine type & typical amount/day: _____

Alcohol & Drug Screening

Have you ever used drugs other than those required for medical purposes? ☐ Yes ☐ No

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2–4 times/month ☐ 2–3 times/week ☐ 4 or more times/week

How many standard drinks containing alcohol do you have on a typical day?

☐ None, I do not drink ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10 or more

How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Sexual Health

Currently sexually active? ☐ Yes ☐ No

Partners in past 12 months: ☐ Men ☐ Women ☐ Both men and women ☐ Another gender ☐ No sexual partners

Number of partners: ____ Sexual contact includes: ☐ Vaginal ☐ Oral ☐ Anal

Condom/barrier use: ☐ Always ☐ Sometimes ☐ Never ☐ Not applicable

Ever diagnosed with an STI? ☐ No ☐ Yes — Type: _____

Would you like to be tested for HIV? ☐ Yes ☐ No

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

Problem	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
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	☐	☐	☐	☐

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

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

Problem	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble Relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

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

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HOME SAFETY

What is your current housing situation?

☐ I have housing ☐ I do not have housing (staying with others/hotel/shelter/outside) ☐ I choose not to answer

Are you worried about losing your housing?

☐ Yes ☐ No ☐ I choose not to answer

What is the highest level of school that you have finished?

☐ Less than a high school degree ☐ High school diploma or GED ☐ More than high school ☐ I choose not to answer

What is your current work situation?

☐ Unemployed and seeking work ☐ Part time or temporary work ☐ Full time work ☐ Otherwise unemployed but not seeking work ☐ I choose not to answer

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply

☐ Food ☐ Clothing ☐ Utilities ☐ Child care ☐ Medicine or any health care ☐ Phone ☐ Other ☐ I do not have problems meeting my needs ☐ I choose not to answer

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes — medical appointments/medications ☐ Yes — non-medical meetings/work/daily needs ☐ No ☐ I choose not to answer

How often do you see or talk to people that you care about and feel close to?

☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week ☐ More than 5 times a week ☐ I choose not to answer

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ I choose not to answer

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

☐ Yes ☐ No ☐ I choose not to answer

Are you a refugee?

☐ Yes ☐ No ☐ I choose not to answer

What country are you from?

☐ United States ☐ Country other than the United States _____ ☐ I choose not to answer

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I have not had a partner in the past year ☐ I choose not to answer

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WHAT IS A YEARLY VISIT?

A yearly visit is a wellness check to make sure there aren't any issues going on with your body that you are unaware of. It has other names: Wellness Visit, Preventative Visit, Annual Visit, etc. This visit is billed to your insurance based on your age at the time of the visit.

What is included:

A physical exam

Vital Signs

Scheduling of indicated screening tests (mammogram, colonoscopy, immunizations etc.)

What is not included:

Management of established problems

Management of new concerns

How are chronic medical conditions or new concerns billed?

These are done based on the level of complexity of the visit and how many problems are addressed.

What does this mean?

We are required to document stability of medical conditions on a routine basis, and with any change in condition; to not document this would put us at risk of liability if something were to happen to you. Legally we are required to bill your insurance the appropriate codes for the service we provide. To do otherwise is considered fraud.

If you come in for a yearly visit, and have other medical concerns, or are overdue for management of your chronic medical conditions (hypertension, diabetes, copd, thyroid, depression, etc.) You may incur a separate charge for this service. (a copay or deductible.) This depends on your insurance coverage.

We recognize that this is unfamiliar to many patients, which is why we have written up this notification. We would like to point out that these rules were set by the US Government and insurance carriers, and it is our job to follow all billing rules.

By signing this form you are acknowledging receipt of this notification.

Signature Pages: Electronic Signature: By typing my name in any following signature field, I understand and agree that my typed name constitutes my electronic signature and has the same force and effect as my handwritten signature.

Signature: _____ Date: _____