Patient Registration Form

Patient Information
(*We ask for this information to identify you and ensure we have accurate records for your care. While Near North Health recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If you use a name and/or pronouns different from these, please let us know below, as indicated. If you are unsure what to list, ask a member of our team for clarification.*)

- **Last Name:** ____
- **First Name:** ____
- **Middle Initial:** ______________
- **Date of Birth (mm/dd/yyyy):** ______________
- **Sex assigned at birth:**
  ☐ Male ☐ Female ☐ Prefer not to disclose
- **Social Security Number:** ______________
- **Address:**
  ____
- **Apt/Unit #:** ______________
- **City:** _______________________
- **State:** __________________
- **Zip Code:** ______________

How would you like our staff to refer to you?:

- **Preferred Name** _________________________
- **Pronouns:** ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: ___________

Contact Information
(*We ask for your contact information so we can reach you regarding appointments, follow-ups, and health reminders.*)

- **Primary Phone Number:** ☐ Home ☐ Cell ☐ Work
  - (______) ______ - ____________
  - **Ok to leave voicemail?** ☐ Yes ☐ No

- **Alternate Phone Number:** ☐ Home ☐ Cell ☐ Work
  - (______) ______ - ____________
  - **Ok to leave voicemail?** ☐ Yes ☐ No
- **Email Address:** _______________________________________
- **Emergency Contact:** _______________________________________
  - **Relationship to Patient:** __________________________
  - **Phone Number:** (______) ______ - ____________

Employment Status
(*We ask for employment details to assess insurance coverage and understand factors that may impact your health.*)

- **Employment Status (check one):**
  ☐ Employed Full-Time ☐ Employed Part-Time ☐ Self-Employed
  ☐ Retired ☐ Unemployed ☐ Student ☐ Other: ______________

Insurance: What kind of health insurance do you have?
☐ Medicaid
☐ Medicare
☐ Private insurance
☐ Uninsured *(If you are uninsured, Near North Health offers a sliding fee discount program. Please ask to speak to a financial counselor for assistance. We are committed to treating all patients, regardless of their ability to pay.)*

Demographic Information
(*We collect demographic information such as race, ethnicity, and language to better understand our patient population. This information is confidential and will not affect your care.*)

- **Race (check all that apply):**
  ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
  ☐ Vietnamese ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro
  ☐ Samoan
  ☐ Black or African American ☐ American Indian or Alaskan Native ☐ White
  ☐ Other Asian ☐ Prefer Not to Disclose
- **Ethnicity:**
  ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Specify
- **Sexual Orientation:**
  ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Don't Know ☐ Prefer Not to Disclose ☐ Other: ___________

- **Gender Identity (How do you identify yourself?):**
  ☐ Male ☐ Female ☐ Female-to-Male/Transgender Male/Trans Man
  ☐ Male-to-Female/Transgender Female/Trans Woman ☐ Genderqueer ☐ Choose Not to Disclose ☐ Other: ____________
- **Marital Status:**
  ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Prefer Not to Disclose
- **Preferred Language:**

  ☐ English ☐ Español ☐ Français ☐ 普通话 ☐ Sign Language ☐ Other:
  ____
  - **Do you need an interpreter?** ☐ Yes ☐ No

Advanced Directive
(*We ask about an advanced directive to ensure we follow your healthcare wishes if you are unable to communicate them.*)

- **Do you have an Advanced Directive?**
  ☐ Yes ☐ No
  If yes, please provide a copy for your records.

Referral Source
(*Understanding how you found us helps improve our outreach and community services.*)

How did you hear about Near North Health? (Check all that apply)
☐ Family/Friend ☐ Health Provider ☐ Hospital ☐ Insurance Plan ☐ Employer ☐ Community Organization ☐ Internet ☐ Social Media
☐ Church ☐ Health Fair/Event ☐ TV/Radio ☐ Newspaper/Ad ☐ School ☐ Other:
____

Veteran, Agricultural Worker, and Housing Status
(*We collect this information to connect you to services or programs specific to veterans, agricultural workers, and people experiencing housing challenges.*)

- **Veteran Status:**
  ☐ Veteran ☐ Not a Veteran
- **Are you Homeless?**
  ☐ Yes ☐ No
  If yes, select living arrangement:
  ☐ Permanent Supportive Housing ☐ Shelter ☐ Transitional ☐ Street ☐ Doubling Up ☐ Other: ___________

- **Are you an Agricultural Worker?**
  ☐ Yes ☐ No
  If yes, please select one:
  ☐ Migratory ☐ Seasonal

Preferred Communication Methods
(*We ask for your preferred communication methods so we can contact you in the way that is most convenient for you.*)

- **Preferred Methods of Contact:**
  ☐ Phone Call ☐ Text Message ☐ Email ☐ Secure Messaging via Patient Portal ☐ Postal Mail
- **Do Not Contact via:**
  ☐ Phone Call ☐ Text Message ☐ Email ☐ Secure Messaging via Patient Portal ☐ Postal Mail
- **May we share your information with a caregiver, spouse, or other designated person?**
  ☐ Yes ☐ No
  If yes, please provide their contact information:
  Name: ________________________________
  Relationship: ___________________________
  Phone Number: ____________________________

Preferred Pharmacy
(*We collect your preferred pharmacy information to ensure your prescriptions are sent to the correct location.*)

- **Pharmacy Name:** ____
- **Pharmacy Address:** _______________________________________

Consent for Treatment and Authorization

I hereby give my consent and authorize **Near North Health** to treat any medical or mental health condition. I understand that the care provider will explain my condition, the recommended treatment, alternative treatment options, and any potential risks involved before proceeding with care.

I also authorize the care provider to perform any additional or different treatment that is necessary if, during the course of treatment, a condition is discovered that was not previously known.

I understand that **Near North Health** operates a primary care practice that integrates behavioral health services, meaning that behavioral health staff are part of my medical team. I acknowledge that seeing a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. If my insurance coverage is insufficient, I understand that I will be responsible for the remaining balance.

Treatment, Payment, and Data Agreement

- I authorize examination and treatment for this and all future medical or mental health visits.
- I understand that I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify, including a sliding scale fee program.
- I am responsible for providing accurate and up-to-date insurance information.
- I authorize a photocopy of this form to serve as the original, and I permit the use of this signature on all insurance submissions.
- I authorize the release of any necessary information to secure payment of benefits.
- I consent to **Near North Health** sending me one or more messages related to my healthcare. I understand that data usage costs may apply based on my mobile carrier plan.
- I understand that **Near North Health** may use non-identifiable data provided by patients to determine general characteristics of the communities it serves.

Summary of Near North Health's Notice of Privacy Practices

At **Near North Health**, we use your health information in several ways to ensure you receive quality care. Here are some of the key ways we may use and share your information:

1. **Treatment**: We will use and disclose your health information to provide, coordinate, or manage your health care and related services. For example, we may share your information with a specialist or a home health agency involved in your care to ensure you receive the appropriate treatment.
2. **Payment**: Your health information will be used to obtain payment for the health care services provided to you. For instance, we may need to share your information with your insurance plan to get approval for services or hospital admissions.
3. **Health Care Operations**: We may use or disclose your health information for our business operations, such as quality assessment, staff training, licensing, and more. For example, we may share your information with medical students in training or use a sign-in sheet in our office.

4. **Other Uses Without Authorization**: We may also use or disclose your information in certain situations without your authorization, such as when required by law, for public health purposes, to report abuse or communicable diseases, for legal proceedings, law enforcement, organ donation, research, national security, and workers' compensation.
5. **Authorization Required for Other Uses**: Any other use or disclosure of your health information will require your written authorization, unless required by law. You may revoke your authorization at any time, in writing, except where we have already acted on it.

A full copy of our **Notice of Privacy Practices** is available to anyone who asks for it. **Near North Health** will also prominently post and make the notice available on our website at www.nearnorthhealth.org, and in patient waiting areas, in compliance with federal law.

I certify that the above information is true and correct. I have received a summary of **Near North Health's** Notice of Privacy Practices, and I am aware of how to obtain a full copy if desired.

- **Patient's name used, if different from chart:** ________________________________
- **Signature (Patient/Legal Guardian):** ________________________________
- **Date:** ________________________

NEAR NORTH HEALTH
Minor Patient Registration Form

Child's Information

- **Child's Legal Name: ____**
  First Name __________________________
  Middle Initial ______________
  Child's Name used (if different): ___________________________________
- **Child's Legal Sex:**
  ☐ Male ☐ Female
  (*Note: While Near North Health recognizes a variety of gender identities, legal documentation may require the sex listed on insurance.*)
- **Child's Pronouns used: ___________________________________**
- **Child's Date of Birth (mm/dd/yyyy): ______________**
- **Child's Social Security Number: ______________**
- **State ID # (if applicable): ______________**

Parent/Guardian Information

(*For patients under 18, we require parent/guardian contact information.*)

- **Parent/Guardian Name: ____**
  - **Date of Birth: ______________**
  - **Relationship to Child: ___________________________________**
  - **Phone Number: ______________**
- **Other Parent/Guardian Name: ____**
  - **Date of Birth: ______________**
  - **Relationship to Child: ___________________________________**
  - **Phone Number: ______________**
- **Parent/Guardian Occupation: ___________________________________**

- **Employer/School Name:** ____________________________________
- **Is the child covered under school or employer insurance?** ☐ Yes ☐ No

---

Contact Information

(*Your answers help us reach you quickly and discreetly with important information.*)

- **Home Phone:** (______) ______ - _____________
  - **Ok to leave a voicemail?** ☐ Yes ☐ No
- **Cell Phone (check whose phone):**
  ☐ Child ☐ Parent/Guardian
  - (______) ______ - _____________
  - **Ok to leave a voicemail?** ☐ Yes ☐ No
- **Work Phone (check whose phone):**
  ☐ Child ☐ Parent/Guardian
  - (______) ______ - _____________
  - **Ok to leave a voicemail?** ☐ Yes ☐ No
- **Best number to use:**
  ☐ Home ☐ Cell ☐ Work
- **Address:**
  ____
  - **City:** ________________________
  - **State:** ___________________
  - **Zip Code:** _______________

Email Information

- **Patient's Email Address (for those aged 12 and older):**
  ____
- **Parent/Guardian Email Address (for those under 12):**
  ____

Preferred Communication

(*How would you like to receive written correspondence?*)
☐ Secure Email (patient portal) ☐ Postal Mail ☐ Other:

____

Demographic Information
(*We collect demographic information such as race, ethnicity, and language to better understand our patient population. This information is confidential and will not affect your care.*)

- **Race (check all that apply):**
  ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
  ☐ Vietnamese ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro
  ☐ Samoan
  ☐ Black or African American ☐ American Indian or Alaskan Native ☐ White
  ☐ Other Asian ☐ Prefer Not to Disclose
- **Ethnicity (check all that apply):**
  ☐ Hispanic/Latino ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Central American ☐ South American
  ☐ Non-Hispanic/Latino ☐ Middle Eastern/North African ☐ Decline to Specify
- **Preferred Language:**

  ☐ English ☐ Español ☐ Français ☐ 普通话 ☐ Sign Language ☐ Other:

  ____

  - **Do you need an interpreter?** ☐ Yes ☐ No
- **For patients over 12 years old:**
  How do you think of yourself?
  ☐ Male ☐ Female ☐ Transgender ☐ Nonbinary ☐ Other:

  ____
  ☐ Prefer not to say

Consent for Minor Treatment and Authorization

I authorize Near North Health to provide medical and/or behavioral health care to my child including, but not limited to, diagnostic examinations (including radiology and laboratory

testing), tuberculosis screening, verification and/or administration of immunizations, and any necessary medical treatment and behavioral health counseling. For surgical procedures or more extensive medical care, attempts will be made to contact me before such care is initiated.

I understand that care may be provided without my consent when, in the opinion of the clinician, a delay in treatment would endanger the life, limb, or behavioral well-being of the patient. I also understand that if an injury or illness is determined to be life-threatening, an ambulance will be called to take my child to the hospital, and the clinician will make every effort to contact me.

Conditions When Treatment Can Be Provided Without Parental Consent

According to Illinois law, there are certain circumstances under which treatment may be provided without parental consent:

1. **Emergency Treatment:** Medical treatment may be provided without consent if delaying treatment would endanger the life, limb, or health of the child.
2. **Outpatient Counseling and Psychotherapy (for minors aged 12 and older):** Minors aged 12 and older may consent to outpatient counseling and psychotherapy without parental consent, but if the minor is under 17, the number of sessions is limited to eight 90-minute sessions until parental consent is obtained.
3. **Drug or Alcohol Abuse Treatment (for minors aged 12 and older):** Minors aged 12 and older may consent to treatment for drug or alcohol abuse for themselves or a family member, and providers are not required to notify parents or guardians.
4. **Minors Who Are Married, Pregnant, or Parents:** Minors who are married, pregnant, or parents may consent to medical and surgical procedures without parental consent.

Treatment, Payment, and Data Agreement

I understand and agree to the following:

- **Treatment:** I authorize examination and treatment for my child during this and all future visits.
- **Payment:** I am responsible for all charges and deductibles. Financial assistance, including a sliding fee discount program, is available for those who qualify.

- **Insurance:** I will provide accurate and current insurance information.
- **Authorization for Insurance Claims:** I authorize the release of all information necessary to secure payment of benefits.
- **Use of Data:** I understand that Near North Health may use aggregated data from its patients to determine general characteristics of the communities it serves, without identifying individual patients.

Summary of Near North Health's Notice of Privacy Practices

Near North Health is committed to protecting the privacy of your health information. We may use and disclose your child's health information for:

1. **Treatment:** Sharing information with other healthcare providers for continuity of care.
2. **Payment:** To bill and collect payment from you or your insurance.
3. **Health Care Operations:** For activities related to running the health center, such as quality improvement and training.

Your Rights:

- You have the right to access your child's health records.
- You have the right to request restrictions on how your child's health information is used and disclosed.
- You have the right to request an amendment to your child's health records.

A full copy of our **Notice of Privacy Practices** is available to anyone who asks for it. **Near North Health** will also prominently post and make the notice available on our website at www.nearnorthhealth.org, and in patient waiting areas, in compliance with federal law.

Parent/Guardian Acknowledgement

I have read and fully understand this consent form, the treatment, payment, and data agreement, and the summary of the notice of privacy practices. I understand that this consent is valid until my child reaches the age of 18 or until I revoke it in writing.

- **Parent/Guardian Signature:** ____
- **Date:** __________________________

Additional Information

- **Witness (optional): ____**
- **Date: __________________________**

NEAR NORTH HEALTH
Financial Guarantor Form

Please Print – Fill in All Areas

Guarantor Information

- **Guarantor's Legal Name:**
  Last Name: ____
  First Name: ____
  Middle Initial: ______________
  Date of Birth: ______________
- **Home Phone:** (______) ______ - ____________
- **Cell Phone:** (______) ______ - ____________
- **Work Phone:** (______) ______ - ____________
- **Social Security Number:** ______________

Insurance Information

- **Your Insurance Company:** ____________________________________
- **Phone Number for Eligibility/Verification:** (______) ______ - ____________
- **ID/Policy Number:** ____________________________________
- **Group Number:** ____________________________________
- **Policy Effective Date:** ______________
- **Co-Payment/Co-Insurance or Deductible:** ____________________________________
- **Employer/School Name:** ____________________________________
  Employer/School Address: ____________________________________
  City: __________________________
  State: ______________
  ZIP: ______________

If covered under another person's insurance policy, please complete the following:

- **Primary Subscriber's Name:** ____________________________________
- **Primary Subscriber's SSN:** ______________
- **Relationship to You:** ____________________________________
- **Primary Subscriber's Employer:** ____________________________________
- **Primary Subscriber's Employer's Address:** ____________________________________
  City: __________________________
  State: ______________
  ZIP: ______________
- **Primary Subscriber's Phone Number:** (______) ______ - ____________
- **Primary Subscriber's Policy Number:** ____________________________________
- **Primary Subscriber's Group Number:** ____________________________________

Authorization and Assignment of Insurance Benefits / Release of Medical Information

I authorize and request my insurance company or companies to pay benefits directly to **Near North Health** for services rendered. I authorize the release of any medical records and/or other information required by my insurance company or its designated review agents who provide insurance benefits on my behalf. This may include my employer, workman's compensation insurance, the Social Security Administration, and/or the Centers for Medicare & Medicaid Services, as needed to determine benefits and process insurance claims.

I understand that I am responsible for notifying my Primary Care Provider of any pre-certifications, or authorizations required by my insurance plan for medical services. If services are rendered without the required insurance approval, I understand that I may be responsible for any reduced or denied coverage.

Financial Agreement

Near North Health strives to make healthcare accessible to all, regardless of ability to pay. We offer a sliding fee discount program and financial assistance for those who qualify. While we ask for payment at the time of treatment, we understand that circumstances may vary. If you are unable to pay in full, please let us know, and we can discuss payment options.

You may receive separate bills for services provided by other healthcare professionals, such as laboratory or specialty providers. If your insurance denies any charges, we ask that you settle any outstanding balances within 30 days, if possible. If additional assistance is needed, please reach out to our financial counselors.

In cases where balances remain due to co-payments, deductibles, or other reasons, we will work with you to arrange payment. If necessary, we may refer accounts to a collection agency as a last resort, but we will make every effort to work with you before that step. A fee may be applied for returned checks.

Certification

I certify that the information provided is accurate and complete. I agree to inform Near North Health of any changes in insurance coverage or personal information. I permit a copy of this authorization and signature to be used in place of the original for all insurance claim submissions, whether manual, electronic, or telephonic. I understand that the terms are reaffirmed each time services are rendered.

Guarantor Signature: ____
Print Name: ____
Date: ______________

For Office Use Only
Medical Record #: ____________________________________

NEAR NORTH HEALTH
Authorization for Release of Information

Patient Information

- **Patient Name:** ____
- **Date of Birth:** ______________
- **Social Security Number (optional):** ______________
- **Address:** ____
- **City:** ____________________
- **State:** ______
- **ZIP:** ______________
- **Phone Number:** ______________

Request for Information

I hereby authorize **Near North Health** to:

- ☐ Release information TO
- ☐ Receive information FROM
- ☐ Exchange information with:

Name of Entity: ____
Address: ____
City: ____________________
State: ______
ZIP: ______________
Phone Number: ______________
Fax Number: ______________

Purpose of Disclosure
(*Select all that apply*)

- ☐ Personal Use
- ☐ Continuity of Care
- ☐ Insurance Purposes
- ☐ Legal Purposes
- ☐ Transfer of Care
- ☐ Disability Determination
- ☐ Employment
- ☐ School or Education
- ☐ Other: ____________________________________

Dates of Information to Be Released

Date range of information requested:
From: ______________ To: ______________

Information to Be Disclosed
(*Initial all that apply*)

- **Complete Health Record** ________
- **X-rays** ________
- **Lab Tests/Reports** ________
- **Progress Notes** ________
- **Radiology Reports** ________
- **Case Management Notes/Reports** ________
- **History and Physical Exams** ________
- **Immunization Records** ________
- **Operative/Procedure Reports** ________
- **EKG/EEG** ________

- **Billing Records ________**
- **Medication Records ________**
- **Other (specify): ____________________________________**

Sensitive Information
(*Initial all that apply—WITHOUT your specific authorization, the information will* ***NOT*** *be released.*)

- **Mental/Behavioral Health Information: _______**
- **HIV/AIDS Testing and Treatment Information: _______**
- **Substance Use Disorder Treatment Information (protected by 42 CFR Part 2): _______**
- **Sexually Transmitted Infections (STIs): _______**
- **Genetic Testing Information: _______**
- **Domestic Violence/Sexual Assault Information: _______**
- **Reproductive Health Information: _______**

Method of Release
(*Select all that apply*)

- ☐ Verbal Disclosure
- ☐ Paper Copy
- ☐ Secure Email (Patient Portal)
- ☐ Fax
- ☐ CD
- ☐ Pickup at Clinic: _____________
- ☐ Mail to Address Above
- ☐ Mail to Different Address: ______________________

Copying Rates for the State of Illinois

At Near North Health, we strive to make healthcare accessible and affordable for all patients. We charge for copying records only to cover basic administrative costs, and we offer sliding fee discounts to those who qualify. If you have concerns about fees, please contact our financial counseling team for assistance.

- **Paper Copies:**
  - First 25 pages: No charge
  - 26-50 pages: $1.00 per page
  - 51 pages or more: $0.50 per page
- **Electronic Records:**
  - $0.75 per record
- **X-rays or Other Media:**
  - Actual reproduction cost

Expiration and Revocation

This authorization is valid until: _______________ (*Select a date no more than 12 months from signature*).

I understand that I may revoke this authorization at any time by submitting a written revocation request to Near North Health. Any revocation will not apply to records already released under this authorization before the receipt of the revocation. For more information about the revocation process, please contact Medical Records.

Acknowledgment and Consent

I understand that:

- This authorization is voluntary.
- Once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations, except where prohibited by law (e.g., for substance use records).

- My treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization, but failure to sign may impact my ability to participate in certain programs or activities.
- I may refuse to sign this authorization.

A copy of this authorization is as valid as the original.

Signature of Person Authorizing Release: ____
(**Please specify relationship if other than patient:** _______________________________)
Date: ______________

Witness (optional): ____
Date: ______________

Welcome to Near North Health!

At Near North Health, we are committed to providing comprehensive care for all our patients, regardless of their ability to pay. As a Federally Qualified Health Center (FQHC), we believe that good health goes beyond medical care—it includes mental, emotional, and social well-being. That's why we ask for information about your health history, lifestyle, and social factors that may affect your overall health. We view mental health as an essential part of your overall health and will work with you to provide the best possible care in every aspect of your life.

The information you provide helps us create a personalized plan for your care and ensures that we can connect you with any additional resources you may need. Your responses are confidential and will not affect your ability to receive care. If you have any questions or need assistance filling out this form, please let one of our staff members know.

Thank you for choosing Near North Health. We look forward to partnering with you in your healthcare journey!

Health History Form

Patient Information

- **Patient Name:** ____
- **Date of Birth:** ______________
- **Gender:** ____
- **Preferred Name (if different):** ____
- **Pronouns:** ____
- **Primary Care Provider (if any):** ____

Medical History

Please check all that apply to you or your family members:

- **Allergies:** ☐ Yes ☐ No
  If yes, list: ____
- **Asthma:** ☐ Yes ☐ No
- **Diabetes:** ☐ Yes ☐ No

- Type: ☐ Type 1 ☐ Type 2
- Last A1C (if known): ___________

- **Heart Disease:** ☐ Yes ☐ No
- **High Blood Pressure:** ☐ Yes ☐ No
- **Stroke:** ☐ Yes ☐ No
- **Kidney Disease:** ☐ Yes ☐ No
- **Cancer (type):** ____
- **Other conditions (please specify):** ____

Surgical History

List any surgeries you have had, and the year they were performed:

- Surgery: _________________________________ Year: ____________
- Surgery: _________________________________ Year: ____________

Hospitalizations, Surgeries, Serious Injuries

- Have you been hospitalized in the last 12 months? ☐ Yes ☐ No
  If yes, list reason and date: ________________________________

Medications

Please list all medications you are currently taking (include over-the-counter medications, supplements, and prescriptions):

- Medication: _____________________________ Dosage: ___________
- Medication: _____________________________ Dosage: ___________

Immunization History

Please check if you have received any of the following vaccines:

- ☐ Flu Shot
- ☐ COVID-19 Vaccine
- ☐ Hepatitis B
- ☐ Tetanus
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Pneumonia
- ☐ Other: ____

Staying Healthy Assessment Questions

1. **Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?**
   ☐ Yes ☐ No ☐ Skip
2. **Do you eat fruits and vegetables every day?**
   ☐ Yes ☐ No ☐ Skip
3. **Do you limit the amount of fried food or fast food that you eat?**
   ☐ Yes ☐ No ☐ Skip
4. **Are you easily able to get enough healthy food?**
   ☐ Yes ☐ No ☐ Skip
5. **Do you drink soda, juice drinks, sports, or energy drinks most days of the week?**
   ☐ No ☐ Yes ☐ Skip
6. **Do you often eat too much or too little food?**
   ☐ No ☐ Yes ☐ Skip
7. **Are you concerned about your weight?**
   ☐ No ☐ Yes ☐ Skip
8. **Do you exercise or spend time doing activities, such as walking, gardening, or swimming, for 30 minutes a day?**
   ☐ Yes ☐ No ☐ Skip

Social Determinants of Health (SDOH) Screen

We ask these questions to help understand your overall health and any social factors that may be affecting you. Your answers are confidential.

- **Housing Situation:** Where are you currently living?
  ☐ I own/rent my own home
  ☐ I stay with family/friends
  ☐ Homeless (living in a car, shelter, or outdoors)
  ☐ Other: ______________________
- **Food Security:**
  In the past 12 months, did you worry that your food would run out before you had money to buy more?
  ☐ Yes ☐ No
- **Transportation:**
  Do you have access to reliable transportation to get to medical appointments?
  ☐ Yes ☐ No
- **Utilities:**
  In the past 12 months, have you had trouble paying your utility bills (electricity, water, etc.)?
  ☐ Yes ☐ No
- **Social and Emotional Health:**
  In the past year, have you felt unsafe in your home?
  ☐ Yes ☐ No
- **Other Needs:**
  Do you need help with any of the following?
  ☐ Accessing affordable housing
  ☐ Finding food assistance
  ☐ Paying for medical care
  ☐ Finding childcare
  ☐ Other: ____

Mental Health Screen

Please answer the following questions to help us understand your mental health needs:

- **Feeling down, depressed, or hopeless:**
  Over the past two weeks, how often have you felt down, depressed, or hopeless?
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
- **Feeling nervous, anxious, or on edge:**
  Over the past two weeks, how often have you felt nervous, anxious, or on edge?
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
- **Trouble concentrating:**
  Over the past two weeks, how often have you had trouble concentrating on things, such as reading or watching television?
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
- **Sleep patterns:**
  Do you have difficulty sleeping or sleep too much?
  ☐ Yes ☐ No
- **Current mental health treatment:**
  Are you currently receiving treatment for any mental health conditions?
  ☐ Yes ☐ No
  If yes, please list: ____

Lifestyle and Habits

- **Tobacco Use:**
  Do you currently use tobacco products?
  ☐ Yes ☐ No
  If yes, how many per day: ___________
- **Alcohol Use:**
  Do you drink alcohol?
  ☐ Yes ☐ No
  If yes, how many drinks per week: ___________
- **Drug Use:**
  Do you use any substances like marijuana, cocaine, ecstasy, or other drugs for fun or relaxation? (These are sometimes called 'recreational drugs').
  ☐ Yes ☐ No

- **Exercise:**
  How often do you exercise?
  ☐ Daily ☐ Weekly ☐ Rarely ☐ Never

Family History

Please list any family history of the following conditions and indicate the relationship:

- **Heart Disease:** Relationship: _______________
- **Diabetes:** Relationship: _______________
- **Stroke:** Relationship: _______________
- **Cancer (type):** Relationship: _______________
- **Mental Health Issues:** Relationship: _______________

Male Health (if applicable)

- **Last prostate exam:** Date: ____________ ☐ Normal ☐ Abnormal
- **Do you have any issues with urination?** ☐ Yes ☐ No
  If yes, please describe: ____
- **Have you experienced any sexual health issues (e.g., erectile dysfunction)?** ☐ Yes ☐ No
  If yes, please describe: ____
- **Have you ever had a prostate-specific antigen (PSA) test?** ☐ Yes ☐ No
  - Date of last test: ____________ ☐ Normal ☐ Abnormal
- **Testicular pain or lumps:** ☐ Yes ☐ No
  If yes, please describe: ____
- **Other concerns regarding sexual or reproductive health:**
  ____

Women's Health (if applicable)

- **Are you currently pregnant?** ☐ Yes ☐ No
- **Last menstrual period:** _______________

- **Birth control method:** ☐ None ☐ Pills ☐ Other: _______________
- **Number of pregnancies:** ______________
- **Number of live births:** ______________
- **Do you Do you think you might want to have (more) children at some point in the future?** ☐ Yes ☐ No
    - **If yes, when might that be** ☐ Trying now, or very soon ☐ Sometime Soon (1-2 years) ☐ No time soon
- **Last Pap smear:** Date: ___________ ☐ Normal ☐ Abnormal
- **Last Mammogram:** Date: ___________ ☐ Normal ☐ Abnormal

Dental and Vision History

- **Dental Health:**
  Do you have any current dental pain or issues? ☐ Yes ☐ No
  Last dental exam: ___________
  Do you wear dentures? ☐ Yes ☐ No
- **Vision Health:**
  Do you have any current vision issues? ☐ Yes ☐ No
  Last vision exam: ___________
  Do you wear glasses or contact lenses? ☐ Yes ☐ No

Additional Information

Is there anything else you would like us to know about your health or social needs?

Signature
Patient Signature: ____
Date: ______________