

<b>NAME:</b>	<b>DOB:</b> <i>mm/dd/yyyy</i>	<b>DATE:</b>
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<b>HEALTH ASSESSMENT</b>
What is most important to you about your medical care? <i>(e.g. communication, prevention, wellness planning)</i>
What specific concerns would you like to address with your new clinician?

<b>MEDICATIONS &amp; ALLERGIES</b>				
Please list all your current medications and allergies <i>(including vitamins &amp; supplements)</i> .				
Item	Dose	Frequency	Taken for	Prescribed by
1.				
2.				
3.				
4.				
5.				
<b>Allergies to medication and other items:</b>				
1.			Reaction:	
2.			Reaction:	
Preferred pharmacy:		Phone:	Fax:	
Address:				

<b>PERSONAL MEDICAL HISTORY</b>			
Have you ever had any problems with the following: <i>(If yes, please explain.)</i>			
<input type="checkbox"/> Alcohol or substance abuse:	<input type="checkbox"/> Metabolism <i>(diabetes, thyroid etc.)</i>		
<input type="checkbox"/> Blood:	<input type="checkbox"/> Muscle, joint, bones:		
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Nerves and brain:		
<input type="checkbox"/> Digestion:	<input type="checkbox"/> Skin and hair:		
<input type="checkbox"/> Ear, nose, throat, eyes:	<input type="checkbox"/> Sleep:		
<input type="checkbox"/> ER Visits:      Type:      Date:	<input type="checkbox"/> Social, mental or emotional health:		
<input type="checkbox"/> Heart or blood vessels:	<input type="checkbox"/> Surgeries:      Type:      Date:		
<input type="checkbox"/> Hospitalizations:      Type:      Date:	<input type="checkbox"/> Women's health:		
<input type="checkbox"/> Kidneys or bladder:	Pregnancies (#):      Births (#):      Living Children (#):		
<input type="checkbox"/> Lungs:	Other:		
<input type="checkbox"/> Men's health:			

<b>FAMILY MEDICAL HISTORY</b>		
Please indicate any family members who have had the following:		
<input type="checkbox"/> Alcohol abuse:	<input type="checkbox"/> Bleeding disorders:	<input type="checkbox"/> Deafness:
<input type="checkbox"/> Arthritis:	<input type="checkbox"/> Breast cancer:	<input type="checkbox"/> Dementia:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Cancer of an unknown type:	<input type="checkbox"/> Depression:
<input type="checkbox"/> Autism:	<input type="checkbox"/> Colon cancer:	<input type="checkbox"/> Diabetes:

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*Family Medical History Continued*

<input type="checkbox"/> Bipolar disorder:	<input type="checkbox"/> Cystic fibrosis:	<input type="checkbox"/> Glaucoma:
<input type="checkbox"/> Heart attack:	<input type="checkbox"/> Lymphoma/Leukemia:	<input type="checkbox"/> Schizophrenia:
<input type="checkbox"/> Heart disease:	<input type="checkbox"/> Osteoporosis:	<input type="checkbox"/> Sickle cell anemia:
<input type="checkbox"/> High blood pressure:	<input type="checkbox"/> Ovarian cancer:	<input type="checkbox"/> Skin cancer:
<input type="checkbox"/> High blood cholesterol:	<input type="checkbox"/> Obesity:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> HIV:	<input type="checkbox"/> Parkinson's disease:	<input type="checkbox"/> Substance abuse:
<input type="checkbox"/> Inherited anemias ( <i>i.e. thalassemia</i> ):	<input type="checkbox"/> Prostate cancer:	<input type="checkbox"/> Thyroid:
<input type="checkbox"/> Inflammatory bowel disease ( <i>e.g. Crohn's disease</i> ):	<input type="checkbox"/> Other cancer:	
<input type="checkbox"/> Any other condition that two or more relatives have?		

<b>SOCIAL HISTORY &amp; LIFESTYLE</b>				
Relationship status: <input type="radio"/> Married or Partnered <input type="radio"/> Single <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed				
What is your highest level of education?		Occupation:		
Do you have any children? <input type="radio"/> Yes <input type="radio"/> No				
Name:	DOB:	Lives at home?	<input type="radio"/> Yes	<input type="radio"/> No
Name:	DOB:	Lives at home?	<input type="radio"/> Yes	<input type="radio"/> No
Who also lives at home with you?				
Do you have any pets? <input type="radio"/> Yes <input type="radio"/> No				
Have you ever been neglected or abused, physically, emotionally or sexually?				
If yes, are you currently living in an unsafe situation? <input type="radio"/> Yes <input type="radio"/> No				
Do you have more than one sexual partner? <input type="radio"/> Yes <input type="radio"/> No				
Sexual Partners: <input type="radio"/> Men <input type="radio"/> Women <input type="radio"/> Both <input type="radio"/> None				
Do you practice safer sex? ( <i>i.e. use condoms</i> ) <input type="radio"/> Yes <input type="radio"/> No				
What are you using for birth control?				
On average, how many alcoholic drinks do you consume per week?				
In the past year, how many times have you had more than 4 (females), 5 (males) drinks in one day?				
Do you use or have you ever used tobacco products?				
Does anyone smoke around you?				
Do you use or have you ever used recreational drugs? <input type="radio"/> Yes <input type="radio"/> No				
How much caffeine do you consume daily? ( <i>coffee, soda, chocolate etc.</i> )				
Do you have concerns about your diet? <input type="radio"/> Yes <input type="radio"/> No				
What do you do for exercise?				
Do you have: <input type="radio"/> A living will <input type="radio"/> Power of attorney <input type="radio"/> Durable power of attorney for health care				

<b>HEALTH MAINTENANCE &amp; PREVENTION</b>			
<b>When was the last time you:</b>			
Visited the dentist:		Had a Tetanus booster:	
Had a blood sugar test:		Had a cholesterol test:	
Had a colon cancer screening:			
Type:	<input type="radio"/> Colonoscopy	<input type="radio"/> Flexible sigmoidoscopy	<input type="radio"/> Occult blood stool test ( <i>card</i> )
<b>Women's Health</b>			
When was your last:	PAP smear?	Mammogram?	Bone density test?
<b>Men's Health</b>			
When was your last:	Prostate exam?		

This section describes the care you received prior to joining Qliance. Please score the following questions using a scale of 0-10, with 0 being strongly disagree and 10 being strongly agree. These questions are *optional* and the answers you provide are confidential.

Score (0-10)

I have been able to get care from my primary care clinician when and how I need it.	
I have had a personal health care provider (doctor, nurse practitioner etc.) who knows me as a person.	
The bulk of my health care needs have been met by my primary care provider's office.	
My primary care clinician has coordinated my care throughout the health care system.	
When I have visited my primary care provider's office, it has been organized and efficient.	

**PATIENT SELF HEALTH ASSESSMENT**

<p><b>How do you rate your health?</b>   <input type="radio"/> Poor   <input type="radio"/> Fair   <input type="radio"/> Good   <input type="radio"/> Very Good   <input type="radio"/> Excellent</p>	
<p><b>During the past 4 weeks, how much trouble have you had engaging in your usual activities because of your physical or emotional health?</b></p> <p><input type="radio"/> No difficulty   <input type="radio"/> A bit of difficulty   <input type="radio"/> Some difficulty   <input type="radio"/> Much difficulty   <input type="radio"/> Could not engage in usual activities</p>	
<p><b>During the past 4 weeks, how much work have you missed due to physical or emotional problems?</b></p> <p><input type="radio"/> Not at all   <input type="radio"/> 10-20%   <input type="radio"/> 21-30%   <input type="radio"/> More than 30%</p>	
<p><b>During the past 4 weeks, has your physical or emotional health limited your social activities?</b></p>	<p><input type="radio"/> Yes   <input type="radio"/> No</p>
<p><b>In the past 3 months have you had any injury or illness that has kept you in bed for all or most of the day?</b></p>	<p><input type="radio"/> Yes   <input type="radio"/> No</p>
<p><b>In the past year, have you gone to the ER for care?</b></p>	<p><input type="radio"/> Yes   <input type="radio"/> No</p>
<p><b>In the past year, have you stayed in the hospital overnight or longer?</b></p>	<p><input type="radio"/> Yes   <input type="radio"/> No</p>