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Preventive Care for a Longer Life.

PIERRE PHYSICIAN GROUP PA

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize PIERRE PHYSICIAN GROUP PA to use and/or disclose my protected health information as described below to

(name and address of recipient)_____

_____

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

_____

_____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying PIERRE PHYSICIAN GROUP PA in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) PIERRE PHYSICIAN GROUP PA agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:

☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

☐ Entire Medical Record	☐ Most Recent 5 Year History	☐ Radiology Reports
☐ Office Chart Notes	☐ All Hospital Records	☐ Operative Reports
☐ Billing Statements	☐ Transcribed Hospital Reports	
☐ Dental Records	☐ History and Physical Exam	☐ Other _____
☐ Laboratory Reports	☐ Emergency and Urgent Care Records	
☐ Pathology Reports	☐ Medical Records for Continuity of Care	_____
☐ Consultation	☐ Diagnostic Imaging Reports	
☐ Discharge Summary	☐ Emergency Room Reports	_____

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

Expiration:

This authorization will expire 180 days from the date of signing or **(insert date)** _____.

Patient Name: _____ **Patient ID #:** _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____ **Relationship to Patient (*if applicable*)**

Printed Name of Patient's Representative (*if applicable*)

☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____ _____

Signature of Witness **Date**

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PIERRE PHYSICIAN GROUP P.A.

OFFICE POLICIES

1315 St. Joseph Parkway, Suite 1503 Houston, Texas 77002
Phone: 713-655-0073 Fax: 713-655-1332

1. I authorize the Physician/Practitioner to provide me/my dependents medical care.

2. In consideration for other patients and the physician/practitioner, please call and cancel your appointment at least 24 hours in advance if you are unable to keep your appointment. There will be a $25.00 charge added to your account for "no show" appointments.

3. If you are late for your appointment, your appointment may need to be rescheduled depending on the physician's/practitioner's schedule.

4. If there is a balance after your insurance has paid and all contractual adjustments have been applied, then you are responsible for the amount and payment is due within 45 days from non-payment from your insurance.

5. Please allow 5-7 days for us to obtain lab results. Please schedule a follow-up appointment to discuss lab results at check out as medical assistants will not disclose results over the phone. This policy protects confidentiality and avoids miscommunication of test results.

6. If your doctor has evaluated you and you require a referral for the condition, please allow 3-7 business days for your insurance company to process and approve your referral. Our referral specialist will work diligently with you and your insurance company to process referrals in a timely manner.

7. Please have your pharmacy FAX any prescription refill requests to 713-655-1332. Phone calls will not be accepted for refills. You may use the Patient Portal for refill request or medical questions. If you are not provided access to the Patient Portal inquire about instructions of how to access your account.

THE PHYSICIAN/PRACTITIONER WILL ONLY ISSUE REFILLS FOR APPROPRIATE TIME PERIODS. YOU MUST CALL AND MAKE AN APPOINTMENT FOR A FOLLOW UP VISIT FOR EVALUATION BEFORE THAT TIME PERIOD LAPSES. PLEASE DO NOT ALLOW MEDICATIONS TO RUN OUT BEFORE YOUR APPOINTMENT. PLEASE NOTE 24 HOUR TURNAROUND TIME IS REQUIRED FOR REFILL AUTHORIZATIONS.

8. If a parent or legal guardian would like their child under the age of 18 to be evaluated in the office, written consent will be required at the time of service.

9. Please remember the clinic operates by appointment only. We will make every effort to accommodate same day appointments upon Physician/Practitioner approval for urgent needs when possible. Your illness or injury will be assessed and it may be determined that you go to the nearest emergency room or urgent care clinic.

10. Please allow a 24 hour response time for non-emergency calls.

11. The physician/practitioner reserves the right to charge for phone consultation with the physician/practitioner. This is not a service that will be covered by your health insurance. You will be responsible for the payment.

12. It is the patient's responsibility to understand your insurance benefits and which laboratories are covered under your plan. If services provided are not covered under your plan, you will be responsible for payment at the time of service. WE DO NOT BILL FOR CO-PAYS.

13. You are required to update your patient information on an annual basis or whenever there has been a change in address, name, phone number or insurance coverage.

14. It is the patient's responsibility to notify the office upon arrival if your insurance information has changed. Failure to do so may result in your insurance not paying the claim due to claim filing deadlines. You will be responsible for payment in full in the event that occurs.

15. Requests for medical records will be accessed a charge of $25.00 and will require payment in advance. Please allow 15 business days for processing if another physician requests records there will not be a charge for this service.

16. If your check is returned for any reason, there will be a $25.00 charge added to your account. Repayment will be accepted in cash or money order only. No future personal checks will be accepted for payment if we receive more than one returned check on your account.

17. Motor vehicle accidents or injuries occurring on private property will be on a cash basis. We do not file insurance for this type of injury. (NO EXCEPTIONS)

18. The physician/practitioner will not prescribe narcotic medications for chronic pain conditions or stimulants for weight loss. Chronic pain conditions that require daily use of controlled substances will be referred to a pain management specialist. The physician/practitioner reserves the right to refer treatment to psychiatry for psychiatric conditions including but not limited to bipolar disorder, attention deficit / hyperactivity disorder, anxiety and depression.

19. This is a physician/practitioner and patient relationship that can be terminated by either party with written notice.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS OF THE OFFICE POLICIES AND AGREE TO THE TERMS STATED THEREIN.

SIGNATURE_____
Insured or Parent/Guardian

PRINTED NAME_____**DATE**_____

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PIERRE PHYSICIAN GROUP P.A.

1315 St. Joseph Parkway, STE 1503
Houston, Texas 77002

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some — and perhaps all — of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the physician/practitioner. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** You will receive monthly statements for your amount due and if your account is over 90 days past due, you will have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our practitioner will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____
Signature of Insured or Parent/Guardian Date

Preventive Care for a Longer Life.

PIERRE PHYSICIAN GROUP P.A.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than the office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, protected health information (PHI) and other documents or information. You consent to the inclusion in electronic health records of sensitive diagnoses and related information. The electronic health records (EHR) will be accessible by Pierre Physician Group PA credentialed physicians/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations (TPO), and/or other purposes permitted by federal and state laws, including HIPAA. The Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of your medical information as required by HIPAA.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, cell phone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you and shall use these means in carrying out TPO. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the physician/practitioner.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I _____ **DATE** _____ **DO HEREBY CONSENT AND**

INSURED OR PARENT/GUARDIAN

ACKNOWLEDGE MY AGREEMENT TO THE TERMS SET FORTH IN THE HIPAA INFORMATION FORM AND ANY SUBSEQUENT CHANGES IN OFFICE POLICY. I UNDERSTAND THAT THIS CONSENT SHALL REMAIN IN FORCE FROM THIS TIME FORWARD

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PIERRE PHYSICIAN GROUP PA

Assignment of Benefits Form

Name of Insured (print):_____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Pierre Physician Group PA for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/ or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

General Patient and Patient Family Responsibilities:
In certain circumstances, the insurance company may send a check for services provided by Pierre Physician Group PA to the patient. In such cases, the patient agrees to endorse and send such a check to Pierre Physician Group PA. If the patient deposits such a check into a personal account, the patient agrees to send Pierre Physician Group PA a check for the equivalent amount.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print):_____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____ Date: ___/___/___

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PIERRE PHYSICIAN GROUP P.A.

PATIENT'S RIGHTS AND RESPONSIBILITIES

Patient's Rights:

- A patient has the right to be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his/her need for privacy.
- A patient has the right to know who is providing medical services and who is responsible for his/her care.
- A patient has the right to be given by his/her care provider, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to receive a copy of a reasonably clean and understandable itemized bill and upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.
- A patient has the right to know if medical treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such experimental research.
- A patient has the right to the confidential handling of medical records and, except when required by law, patients are given the opportunity to approve or refuse the release of medical records.

Patient's Responsibilities:

- A patient is responsible for providing to his/her health care provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters related to their health.
- A patient is responsible for reporting unexpected changes in his/her condition to his/her health care provider.
- A patient is responsible for reporting to his/her health care provider whether he/she comprehends a contemplated course of action and what is expected of him/her.
- A patient is responsible for following the treatment plan recommended by his/her health care provider.
- A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the health care provider 24 hours prior to the scheduled appointment.
- A patient is responsible for his/her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.
- A patient is responsible for following medical office rules and regulations affecting patient care and conduct.

Signature of Insured or Parent/Guardian:_____

PRINTED NAME:_____ **DATE:**_____

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PIERRE PHYSICIAN GROUP PA

ELECTRONIC PRESCRIPTIONS (E-Prescribing)

I voluntarily authorize Pierre Physician Group PA to allow E-Prescribing for my prescriptions, which allows the health care providers to electronically transmit prescriptions to the pharmacy of my choice; review pharmacy benefit information and medication dispense history as long as I am a patient in this office, or until I withdraw my consent.

Signature of Insured or Parent/Guardian_____

PRINTED NAME _____DATE_____

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1315 St Joseph Parkway #1503
Houston, TX 77002

PATIENT INFORMATION Pierre Physician Group P.A.

Patient Name: _____
Last **First** **MI /MAIDEN (If Applicable)**

D.O.B _____ **Sex: M F**
(Date of Birth)

Mailing Address: _____
Street/Apt. #/P.O. Box **City** **State** **Zip**

Home Phone:(_____) _____ **Cell:(_____)** _____

Work:(_____) _____ **E-MailAddress:** _____

Marital Status: Single /Married/ Divorced/ Widowed

Occupation: _____ **Employer** _____

Home/ Work/ Cell
Preferred Contact Number

Name of Spouse: _____ **Daytime Phone:(_____)** _____

Emergency Contact: _____ **Phone:(_____)** _____
(Other Than Spouse)

ONLY COMPLETE THIS SECTION IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR THE BILL

Name: _____
Last **First** **MI /MAIDEN (If Applicable)**

D.O.B _____ **Sex: M F** **Relationship to Patient:** _____
(Date of Birth)

Mailing Address: _____
Street/Apt. #/P.O. Box **City** **State** **Zip**

Home Phone:(_____) _____ **Cell:(_____)** _____

Work:(_____) _____ **E-MailAddress:** _____

PRIMARY INSURANCE COVERAGE

Insurance Company: _____ **Type of Plan:** HMO/PPO/POS/OTHER

ID#_____

Insurance Claims Address:_____
Street/Apt. #/P.O. Box City State Zip

Phone:(___)_____ **Group/Plan#:**_____ **Effective Date:**_____

Policy Holders Information: (If Other Than Patient Only)

Name: _____
Last First MI /MAIDEN (If Applicable)

D.O.B_____ **Relationship to Patient:**_____
(Date of Birth)

SECONDARY INSURANCE COVERAGE (IF APPLICABLE)

Insurance Company: _____ **Type of Plan:** HMO/PPO/POS/OTHER

ID#_____

Insurance Claims Address:_____
Street/Apt. #/P.O. Box City State Zip

Phone:(___)_____ **Group/Plan#:**_____ **Effective Date:**_____

By what means did you discover this practice
current patient/ internet/ family member/ other _____

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INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit _____

Other Concerns: _____

ALLERGIES: List anything you are allergic to (medications, food, bee stings, etc.) and how each affects you:

	Allergy:	**Reaction**
1.	_____	_____
2.	_____	_____
3.	_____	_____

FAVORITE PHARMACY: _____

MEDICATIONS:

Please list all medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins/inhalers.

Drug Name:	Strength:	Frequency Taken:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATION HISTORY:

Immunizations and most recent date

o	Chickenpox	Date: _____	o	Meningococcus	Date: _____
o	Flu Shot	Date: _____	o	MMR (Measles, Mumps, Rubella)	Date: _____
o	Gardasil/HPV	Date: _____	o	Pneumonia (Pneumovax)	Date: _____
o	Hepatitis A	Date: _____	o	Tdap (Tetanus and Pertussis)	Date: _____
o	Hepatitis B	Date: _____	o	Tetanus	Date: _____
			o	Zostavax (Shingles)	Date: _____

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(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY:

Last PAP Smear Date: _____ ❑ Abnormal

Last Mammogram Date: _____ ❑ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause _____

Number of pregnancies: _____ Births: _____

Miscarriages: _____ Abortions: _____

❑ Cesarean Sections If yes, then number of: _____

❑ Bleeding between periods

❑ Heavy periods

❑ Extreme menstrual pain

❑ Vaginal itching, burning, or discharge

❑ Wake in the night to go to the bathroom

❑ Hot flashes

❑ Breast Lump or nipple discharge

❑ Painful intercourse

❑ Sexually active
Current sexual partner is ❑ M ❑ F _____
Do you use condoms? ❑ Yes ❑ No
Other birth control method:

❑ Interested in being screened for STD's

PAST MEDICAL HISTORY:

Please check all that apply:

- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Appendicitis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clots (or DVT)
- ❑ Cancer
  Type: _____
- ❑ Coronary Artery Disease
- ❑ Diabetes – Insulin
- ❑ Diabetes – Non-Insulin
- ❑ Dialysis
- ❑ Diverticulosis/Diverticulitis
- ❑ Fibromyalgia
- ❑ Gallstones
- ❑ Gout
- ❑ Heart Attack
- ❑ Heartburn
- ❑ Heart Murmur
- ❑ Hiatal Hernia
- ❑ HIV or AIDS
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Leg-Foot Ulcers
- ❑ Liver Disease
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Peptic Ulcer Disease
- ❑ Pulmonary Embolism
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ Tuberculosis
- ❑ Other: _____

PAST SURGICAL HISTORY:

Surgery:	Year:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

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FAMILY HEALTH HISTORY:

Has anyone in your family been diagnosed with any of the following? :

❑ Cancer (if so, what type) ❑ Diabetes ❑ Heart Disease ❑ Hypertension

If you checked yes, please fill in the following:

Family Member:	Alive (Yes/No):	Age:	Diagnosis:

YOUR SOCIAL HISTORY

1. OCCUPATION TITLE

_____

2. HIGHEST EDUCATION LEVEL

☐ LESS THAN 8TH GRADE

☐ 9TH

☐ 10TH

☐ 11TH

☐ HIGH SCHOOL

☐ 2 YEAR COLLEGE

☐ 4 YEAR COLLEGE

☐ POST GRADUATE

3. MARITAL STATUS

☐ SINGLE

☐ MARRIED

☐ DIVORCED

☐ WIDOWED

☐ DOMESTIC PARTNER

4. SEXUAL ORIENTATION

☐ HETEROSEXUAL

☐ HOMOSEXUAL

☐ BISEXUAL

5. ADVANCE DIRECTIVE

☐ Yes

☐ No

6. Do you SMOKE CIGARETTES or CIGARS ? ☐ YES ☐ NO IF yes what is your current SMOKING STATUS?

☐ NEVER SMOKER

☐ FORMER SMOKER

☐ CURRENT SOME DAY SMOKER

☐ CURRENT EVERYDAY SMOKER

7. ON AVERAGE HOW MUCH DO YOU SMOKE?

☐ 1/4 PACK PER DAY

☐ 1/2 PACK PER DAY

☐ 1 PACK PER DAY

☐ 2 PACK PER DAY

☐ 3 OR MORE PACKS PER DAY

☐ 1 PACK PER WEEK

☐ 2 PACK PER WEEK

8. HOW OLD WERE YOU WHEN YOU STARTED SMOKING?

_____

9. IF YOU ARE A FORMER SMOKER HOW MANY YEARS HAS IT BEEN SINCE YOUR LAST CIGARETTE ?

_____

10. DO YOU USE CHEWING TOBACCO

☐ Yes

☐ No

11. HOW MANY YEARS HAVE YOU BEEN SMOKING?

_____

12. Alcohol- How often do you have a drink?

☐ NEVER

☐ 1 DRINK MONTHLY OR LESS

☐ 2-4 TIMES A MONTH

☐ 2-3 TIMES A WEEK

☐ 4 OR MORE TIMES A WEEK

13. WHEN YOU HAVE AN ALCOHOLIC DRINK HOW MANY DRINKS DO YOU HAVE AT ONE SITTING?

☐ 1-2

☐ 3-4

☐ 5-6

☐ 7-9

☐ 10 OR MORE

14. HOW OFTEN DO YOU HAVE 6 OR MORE DRINKS IN ONE OCCASION?

☐ NEVER

☐ LESS THAN MONTHLY

☐ MONTHLY

☐ WEEKLY

☐ DAILY OR ALMOST DAILY

15. FOR HOW MANY YEARS HAVE YOU BEEN DRINKING ALCOHOL?

_____

16. How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)?

_____

17. How often do you exercise per week?

☐ NEVER

☐ 1-2 TIMES A WEEK

☐ 2-3 TIMES A WEEK

☐ 3 OR MORE TIMES A WEEK

18. How does your current physical health compare to last year?

☐ SAME

☐ BETTER

☐ WORSE

19. How does your current mental health compare to last year?

☐ SAME

☐ BETER

☐ WORSE

20. Over the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless?

☐ YES

☐ No

21. Over the past 2 weeks, have you often been bothered by little interest or pleasure in doing things?

☐ YES

☐ NO

22. Have you required/used more than a 15 day supply of narcotic medication over the last 12 months for a non-terminal diagnosis? For example hydrocodone, tylenol with codeine?

☐ Yes

☐ No

23. Have you ever lost control of your urine? If so, how big of a problem is it for you?

☐ *YES*

☐ *NO*

☐ BIG PROBLEM

☐ SMALL PROBLEM

☐ NOT A PROBLEM

24. Do you Live alone or with others?

☐ ALONE

☐ WITH OTHERS

25. How often do you have sex without a condom?

☐ NEVER

☐ SOMETIMES

☐ FREQUENTLY

26. How many sexual partners do you have?

☐ NONE

☐ ONE BUT I'M HIS/HER ONLY PARTNER

☐ ONE BUT HE/SHE HAS MULTIPLE PARTNERS

☐ MULTIPLE PARTNERS

27. Do you have any social or financial concerns?

☐ Yes

☐ No

28. How do you move around?

☐ I WALK INDEPENDENTLY

☐ I WALK WITH A CANE OR A WALKER

☐ I USE A WHEELCHAIR

29. Do you have any Difficulty dressing or bathing?

☐ YES

☐ NO

30. Do you have any difficulty with eating or meal preparation?

☐ YES

☐ NO

31. Do you require glasses/ Contacts for routine vision?

☐ YES

☐ NO

32. Do you have hearing issues or require a hearing aid?

☐ YES

☐ NO

33. Do you have a Single or multi-level home?

☐ SINGLE LEVEL

☐ MULTI LEVEL

34. Do you have Difficulty walking or climbing stairs?

☐ YES

☐ NO

35. Are You Able to care for yourself?

☐ YES

☐ NO

36. Do you have Difficulty concentrating, remembering or making decisions?

☐ YES

☐ NO