PERSONAL HEALTH HISTORY

Patient Name: _____

For YES responses please add details.

Overall Well	YES	NO	Menstrual issues	YES	NO
Fatigue	YES	NO	Painful intercourse	YES	NO
Fever or Infectious symptoms	YES	NO	Erectile dysfunction	YES	NO
Weight change	YES	NO	Incontinence	YES	NO
Eye Problems	YES	NO	Blood in urine	YES	NO
Decreased Hearing	YES	NO	Frequent urination	YES	NO
Difficulty Swallowing	YES	NO	Back problems	YES	NO
Ringing in ears	YES	NO	Painful joints or swelling of joints	YES	NO
Snoring	YES	NO	Leg swelling	YES	NO
Cold or heat intolerance	YES	NO	Change in moles	YES	NO
Excessive Sweating	YES	NO	Rash	YES	NO
Excessive Thirst	YES	NO	Dizziness	YES	NO
Breathing problems	YES	NO	Imbalance	YES	NO
Chest pain	YES	NO	Headache	YES	NO
Cough	YES	NO	Weakness	YES	NO
Shortness of breath	YES	NO	Numbness	YES	NO
Wheezing	YES	NO	Memory concerns	YES	NO
Breast Lumps	YES	NO	Tremors	YES	NO
Nipple Discharge	YES	NO	Anxiety	YES	NO
Irregular heartbeat / palpitations	YES	NO	Depression	YES	NO
Abdominal pain / Stomach problems	YES	NO	Sleep difficulties	YES	NO
Blood in stool	YES	NO	Falls in the last year	YES	NO
Constipation	YES	NO	Tobacco use if yes quantity	YES	NO
Diarrhea	YES	NO	Alcohol intake if yes quantity	YES	NO
Heartburn	YES	NO	Other drug use	YES	NO
Nausea	YES	NO	Do you use a walker or cane?	YES	NO
Vomiting	YES	NO	How much physical activity per week? what kind?		
Easy bruising/bleeding	YES	NO			
How are you doing with the cost of prescription meds?					

Other issues you would like to discuss:	**List any over the counter medications:**

PLEASE NOTE: We recognize that some insurance companies offer NO COPAY with complete physical exams. However, those same insurance plans may require us to collect a copay if any of the above problems or any other medical issues are discussed or any medications are presribed or monitored.
This is based on your insurance policy and is not under our control.
Please indicate that you understand by signing below.

Patient Signature: _____	Date _____

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 figety 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, please refer to accompanying scoring card). TOTAL:

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 _____

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_____ _____

Date Print name

Responsibility of patient for services - read carefully

I authorize the release of medical information to to my insurance company and payment of medical benefits directly to Stony Brook Primary Care. This authorization is given for all claims processed in connection with my medical treatment.

If I am a Medicare patient, I understand that I am responsible for payment of any uncovered Medicare services. Further, I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration, or its intermediaries or carriers, any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party except assignment. If I am a MassHealth patient I understand that this practice does NOT bill MassHealth and I will be responsible for any service is not covered by my other insurance plans (e.g. co-pays or coinsurance).

Prior to arriving for any visits at Stony Brook primary care, it is the patient responsibility to verify with us whether or not he she is insured by one of the carriers we are contracted with. For all fees not covered by the patient health insurance, the patient understands he she will be responsible for payment of those fees. Per office policy the patient is responsible for paying any insurance required a co-pay at the time of their visit.

If your visit is related to a motor vehicle accident we do not bill the automobile insurance carrier. Payment for the visit will be your responsibility at the time of visit. We will provide a receipt which can be submitted to the auto insurance company for reimbursement.

Regarding preventative visits (your physical):

Insurance companies offer many different plans. If your insurance company advertises your preventative visit is covered at 100%, then it should be and is. We follow your insurance company‘s policy regarding your preventative visit. If there is additional coding on your bill, which may or may not result in a balance due by you, please consider the following: **a preventative visit is limited to an evaluation of the body and its functions using inspection palpation (feeling with the hand), percussion (tapping with the fingers, and auscultation listening. It does not include management of a stick additions, diagnosis of new conditions, prescription management, or extensive counseling by the practitioner.** When a patient has an appointment for a physical exam and also has an acute chronic or new condition that is managed, such as hypertension, hyperlipidemia, diabetes, GERD, and or many others, we bill for both services. Your insurance company will determine what services are covered under your policy and will notify us what they have deemed to be **your** financial responsibility. **For many people this may result in a co-pay for the visit, even though the preventative physical itself is covered in full.** If you have a balance due after this determination by your insurance company, we will send you a statement showing your balance.

_____**Initial here if you were declining to pay a co-pay today.**

I have read and understand the conditions for payment to the physician outlined above and agree to pay any balance to do as determined by my insurance company.

_____ _____

Patient signature date

_____

Current insurance carrier

asthma.com

Name: _____ **Today's Date:** _____

ASTHMA CONTROL TEST™

Know your score.

The Asthma Control Test™ provides a numerical score to help you and your healthcare provider determine if your asthma symptoms are well controlled.

Take this test if you are 12 years or older. Share the score with your healthcare provider.

Step 1: Write the number of each answer in the score box provided.

Step 2: Add up each score box for the total.

Step 3: Take the completed test to your healthcare provider to talk about your score.

IF YOUR SCORE IS 19 OR LESS, **Your asthma symptoms may not be as well controlled as they could be. No matter what the score, bring this test to your healthcare provider to talk about the results.**

NOTE: If your score is 15 or less, your asthma may be very poorly controlled. Please contact your healthcare provider right away. There may be more you and your healthcare provider could do to help control your asthma symptoms.

					SCORE
1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?					
All of the time **[1]**	Most of the time **[2]**	Some of the time **[3]**	A little of the time **[4]**	None of the time **[5]**	.....
2. During the past 4 weeks, how often have you had shortness of breath?					
More than Once a day **[1]**	Once a day **[2]**	3 to 6 times a week **[3]**	Once or twice a week **[4]**	Not at all **[5]**	.....
3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?					
4 or more nights a week **[1]**	2 to 3 nights a week **[2]**	Once a week **[3]**	Once or twice **[4]**	Not at all **[5]**	.....
4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?					
3 or more times per day **[1]**	1 to 2 times per day **[2]**	2 or 3 times per week **[3]**	Once a week or less **[4]**	Not at all **[5]**	.....
5. How would you rate your asthma control during the past 4 weeks?					
Not Controlled at All **[1]**	Poorly Controlled **[2]**	Somewhat Controlled **[3]**	Well Controlled **[4]**	Completely Controlled **[5]**	.....

TOTAL: .....

This material was developed by GSK.