LEWIS&CLARK COMMUNITY COLLEGE

PATIENT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Patient's last name:	**First:**	**Middle:**	**Marital status** **S / M / D / Sep / W**

Birth date: / /	**Age:**	**Sex:** ❑ **M** ❑ **F**	**Social Security No.:**	**Phone :** **( )**

Street address/PO Box:	**City:**	**State:**	**ZIP Code:**

Primary Care Provider:	**Date of last physical exam:**

INSURANCE INFORMATION

Please give your insurance card(s) and photo ID to the receptionist. You must notify us if this is an accident or work related visit.

Type of Insurance Coverage: ☐ No Insurance ☐ Private Insurance ☐ Medicaid ☐ Medicare

Is this patient covered by insurance?	❑ Yes	❑ No	Email address:

Please indicate primary insurance	❑ Medicare	❑ IDPA/Medicaid	❑ Private Insurance

Policy Holder's name:	Policy Holder's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

STATISTICAL INFORMATION (OPTIONAL) – PATIENT INFORMATION

The LC Family Health Clinic is grant funded. The following information is for statistical purposes. Please complete the following information.

County of Residence:

☐ Greene ☐ Macoupin ☐ Jersey ☐ Calhoun

☐ Madison ☐ Other(Please Specify):

_____

Ethnicity:

☐ White/Non-Hispanic ☐ African American ☐ Hispanic ☐ Asian

☐ American Indian/Alaskan ☐ Hawaiian/Pacific Islander

☐ Other: _____

Do you reside in Public Housing: ☐ Yes ☐ No **Are you a veteran?** ☐ Yes ☐ No

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Based on your family size, please circle the box that best describes your family income. You may choose <u>either</u> annual or monthly. Thank you.

Family Size	ANNUAL INCOME										
1	$11,770	$14,124	$15,6544	$15,890	$16,478	$17,066	$17,655	$20,598	$21,775	$23,540	>$23,540
2	$15,930	$19,116	$21,187	$21,506	$22,302	$23,099	$23,895	$27,878	$29,471	$31,860	>$31,860
3	$20,090	$24,108	$26,720	$27,122	$28,126	$29,131	$30,135	$35,158	$37,167	$40,180	>$40,180
4	$24,250	$29,100	$32,253	$32,738	$33,950	$35,163	$36,375	$42,438	$44,863	$48,500	>$48,500
5	$28,410	$34,092	$37,785	$38,354	$39,774	$41,195	$42,615	$49,718	$52,559	$56,820	>$56,820
6	$32,570	$39,084	$43,318	$43,970	$45,598	$47,227	$48,885	$56,998	$60,255	$65,140	>$65,140
7	$36,730	$44,076	$48,851	$49,586	$51,422	$53,259	$55,095	$64,278	$67,951	$73,460	>73,460
8	$40,890	$49,068	$54,384	$55,202	$57,246	$59,291	$61,335	$71,558	$75,647	$81,780	>$81,780

Family Size	MONTHLY INCOME										
1	$ 981	$1,177	$1,305	$1,324	$1,373	$1,422	$1,471	$1,716	$1,815	$1,962	>$1,962
2	$1,328	$1,593	$1,766	$1,792	$1,851	$1,925	$1,991	$2,323	$2,456	$2,655	>$2,655
3	$1,674	$2,009	$2,227	$2,260	$2,344	$2,428	$2,511	$2,930	$3,097	$3,384	>$3,384
4	$2,021	$2,425	$2,688	$2,728	$2,829	$2,930	$3,031	$3,536	$3,739	$4,042	>$4,042
5	$2,368	$2,841	$3,149	$3,196	$3,315	$3,433	$3,551	$4,143	$4,380	$4,735	>$4,735
6	$2,714	$3,257	$3,610	$3,664	$3,800	$3,936	$4,071	$4,748	$5,021	$5,428	>$5,428
7	$3,061	$3,673	$4,071	$4,132	$4,285	$4,438	$4,591	$5,356	$5,663	$6,122	>$6,122
8	$3,408	$4,089	$4,532	$4,600	$4,771	$4,941	$5,111	$5,963	$6,304	$6,815	>$6,815

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tdap	☐ Pneumonia
	☐ Meningitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ Hepatitis A ☐ 1st ☐ 2nd	☐ Hepatitis B ☐ 1st ☐ 2nd ☐ 3rd
	☐ HPV *Human Papilloma Virus*	☐ Zostavax (Shingles)

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Dosage/Frequency

Allergies

Drug & Non-Drug	Reaction		
	☐ Mild	☐ Moderate	☐ Severe
	☐ Mild	☐ Moderate	☐ Severe
	☐ Mild	☐ Moderate	☐ Severe

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List any medical problems that other doctors have diagnosed					
☐ High Blood Pressure	☐ Diabetes	☐Asthma/COPD	☐ Depression	☐ Other: _____	
☐ High Cholesterol	☐ Heart Disease	☐ Cancer			

Surgeries/Hospitalizations		
Year	Reason	Hospital

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you concerned with your weight?			☐ Yes	☐ No
	How many times a week do you eat fast food?			_____	
Caffeine	☐ None	☐ Coffee/Tea	☐ Soft Drink/Energy Drink		
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	Frequency?			_____	
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	History of tobacco use?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Cigar/ Pipe - #/day	☐ Vapor	
	☐ # of years	☐ Or year quit			
Drugs	Any history or use of recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	Are you currently pregnant or breastfeeding?			☐ Yes	☐ No
Oral Health	When was your last dental exam?			_____	
	Are you currently experiencing any pain in your mouth?			☐ Yes	☐ No
	Do your gums bleed when you brush or floss?			☐ Yes	☐ No
	Have you ever been told that you have periodontal disease or need a "deep cleaning?"			☐ Yes	☐ No
Vision/Hearing	When was the last time you had a vision exam with an optometrist or ophthalmologist?			_____	
	Do you have hearing loss?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you need assistance with daily activities?			☐ Yes	☐ No
	Do you need assistance with medication management?			☐ Yes	☐ No

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FAMILY HEALTH HISTORY									
	Gender	High Blood Pressure	Diabetes	Asthma/ COPD	Heart Disease	Depression	Cancer	High Cholesterol	Other
Father		☐	☐	☐	☐	☐	☐	☐	☐ ___________
Mother		☐	☐	☐	☐	☐	☐	☐	☐ ___________
Siblings	☐ M ☐ F	☐	☐	☐	☐	☐	☐	☐	☐ ___________
	☐ M ☐ F	☐	☐	☐	☐	☐	☐	☐	☐ ___________
	☐ M ☐ F	☐	☐	☐	☐	☐	☐	☐	☐ ___________
	☐ M ☐ F	☐	☐	☐	☐	☐	☐	☐	☐ ___________
	☐ M ☐ F	☐	☐	☐	☐	☐	☐	☐	☐ ___________
	☐ M ☐ F	☐	☐	☐	☐	☐	☐	☐	☐ ___________
Grandmother *Maternal*		☐	☐	☐	☐	☐	☐	☐	☐ ___________
Grandfather *Maternal*		☐	☐	☐	☐	☐	☐	☐	☐ ___________
Grandmother *Paternal*		☐	☐	☐	☐	☐	☐	☐	☐ ___________
Grandfather ***Paternal***		☐	☐	☐	☐	☐	☐	☐	☐ ___________

Consent for Care:

I, with my signature, authorize LC Family Health Clinic, and any employee working under the direction of the provider, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling assessment or review of physical mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with interprofessional healthcare students and other health care professionals for care and treatment.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductible, and other amounts that may be deemed my responsibility by the payment source, as required by my contract with my insurance plan and state regulations.

- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.

- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. LC Family Health Clinic is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

Consent Agreement

I affirm that I have stated all my known medical conditions and answered all questions honestly.

I agree to keep the provider updated as to any changes in my medical profile and understand that there shall be no liability to *Lewis & Clark Community College Family Health Clinic or LCCC Health Services* should I fail to do so.

____ ____________________________

Patient Signature Date

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