# *Live Well in WNC*

## **PATIENT INFORMATION**

Date ______________

Full legal name ________________________________________ Date of birth ______________

Preferred name _____________________________________Preferred pronoun ______________

SSN _______________________________________________Marital status _________________

Mailing address ________________________________________________________________

City ______________________________ State _____________________Zip ______________

Phone number (Home) _________________________ (Cell) ____________________________

Preferred Pharmacy ____________________________________________________________

Employer ________________________________________ Work phone ___________________

Primary Care Physician _________________________________________________________

Preferred language __________________ Race _____________ Hispanic/Latino YES NO

EMAIL ________________________________________________________________________

## **BILLING INFORMATION**

Full legal name of policy holder _______________________________ Date of birth __________

Insurance company _____________________________________________________________

Policy number ____________________________ Group number _________________________

Employer name

_____________________________________________________________________

Secondary insurance YES NO

Insurance company _____________________________________________________________

Policy number ____________________________ Group number _________________________

# *Live Well in WNC*

## Emergency Contact/HIPAA Release Form

Patient Name: ______________________________________ Date of Birth: _______________

***Emergency Contact***

Person to notify in case of emergency or if we are unable to contact you

Name: ______________________ Phone Number: ______________ Relationship: ____________

***HIPAA Release Form***

I have read and fully understand Live Well in WNC's Privacy Notification. I understand that Live Well in WNC may use or disclose my personal health information(PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed. If I choose to restrict how my PHI is used or disclosed I understand it must be submitted to Live Well in WNC in writing. Restrictions are considered on a case by case basis.

I hereby consent that the people listed below are also authorized to receive my PHI, such as treatment plan, payment information, or lab results. I understand that Live Well in WNC will verify the identity of the party listed before any information is given.

This information may be released to:

Name: _____________________________________ Relationship: _________________

Name: _____________________________________ Relationship: _________________

***Messages***

If unable to reach me:

- o You may leave a detailed message.
- o Please leave a message asking me to return your call.
- o Do not leave a message.

Patient Signature: _______________________________ Date: _____________________

Parent/Guardian Signature: ________________________________________

# Grace G. Evins, MD
## Medical History Form

Name ______________________ Date of Birth ____________ Date ____________
Family Doctor ______________________ Other Doctors ____________
If you are a new patient, whom may we thank for referring you to our practice? ____________
Are you transferring care from another doctor, if so, from whom? ____________
What is your main reason for your visit today? ____________
What is your preferred pharmacy (prescriptions will be sent to your pharmacy electronically) ____________
Medication allergies ____________

**General History**
Please **circle** any of the following that apply to you:

| | | | |
|---|---|---|---|
| High blood pressure | Stroke | Cancer | Ulcers |
| Heart disease | Blood clots | Breast | Irritable bowel syndrome |
| Heart attack | Bleeding disorder | Colon | Hepatitis |
| Heart murmur | Anemia | Ovarian | Migraines |
| Rheumatic fever | Asthma | Uterine | Seizure disorder |
| High cholesterol | Chronic lung disease | Other________ | Osteoporosis |
| Diabetes | Tuberculosis | Depression | Arthritis |
| Thyroid Disease | Kidney Disease | Anxiety | GERD |
| Sleep disruption/insomnia | | | |

Other ____________
Physical or sexual abuse, past or present, can create serious physical or emotional problems for women. If this is an issue you would like to discuss, please indicate with a checkmark here_______

**Surgical History**
Please **circle** any of the following that apply to you:

| | |
|---|---|
| Hysterectomy | C-section _______times |
| Vaginal abdominal | Tubes tied |
| Ovaries removal | Breast surgery |
| Left right both | Hernia repair |
| Ovarian cyst removed | Thyroid surgery |

**OB History**
# of pregnancies ____________
# full term births ____________
#abortions/miscarriages ____________
# children living ____________

**Gynecologic History**
Age at your first period _____ years
Period occurs every _____ days and last _____ days
Periods are: regular irregular

Date of last menstrual period. ____________
Birth control method ____________
Date of last pap smear ____________
Was your pap normal ____________

Please **circle** any of the following that apply to you:

| | | | |
|---|---|---|---|
| Heavy periods | Genital warts | Breast problems | Painful sex |
| Severe cramping | Gonorrhea | Pelvic inflammatory disease | Hot flashes |
| Fibroids | Chlamydia | Tubal pregnancy | Night sweats |
| Ovarian cysts | Herpes | Pelvic pain | Bleeding after menopause |
| Abnormal pap smear | Other sexually transmitted | Endometriosis | Urine leakage |
| Cryotherapy/LEEP | disease ____________ | Infertility | Vaginal dryness |
| Memory loss | Decreased Libido | | |

**Brief sexual symptom checklist**
1. Are you satisfied with your sexual function ______Yes ______No (If no, please continue)
2. How long have you been dissatisfied with your sexual function? ____________
3. The problem(s) with your sexual function is: (mark one or more)
   a. Problems with little or no interest in sex
   b. Problems with decreased genital sensation (feeling)
   c. Problems with decreased vaginal lubrication (dryness)
   d. Problems reaching orgasm
   e. Problems with pain during sex
   f. Other ____________
4. Which problem (in question 3) is most bothersome? **Circle** a b c d e
5. Would you like to talk about it with your health care provider? ______Yes ______No

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## MEDICATIONS

Please include dose and frequency, including over the counter medications, vitamins, supplements and herbals

________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

## FAMILY HISTORY

Please include cancer, heart disease, diabetes, high blood pressure, blood clots and any other significant family history:

Mother: ________________
Grandparents: ________________
________________
________________

Father: ________________
Sisters/Brothers: ________________
________________
________________

## SOCIAL HISTORY

Please circle: Single Married Divorced Widowed Same-sex relationship

Tobacco: None_____ Former smoker_____ Current smoker_____ _____packs per day
Alcohol: None_____ Socially_____ Other________________ Amount______drinks per day
Drug Use: None_____ Former use_____ Other________________
Occupation:________________ Sexually active: Yes_____ No_____

## Preventive Health History

| | | |
|---|---|---|
| Are your immunizations up-to-date? | Yes _____ | No_____ |
| Have you had the Hepatitis B vaccination series? | Yes _____ | No_____ |
| Have you had chicken pox or received the varicella vaccine? | Yes _____ | No_____ |
| Have you had a tetanus booster in the past 10 years? | Yes _____ | No_____ |
| Do you take calcium and vitamin D for your bones? | Yes _____ | No_____ |
| Do you take folic acid to prevent birth defects if you get pregnant? | Yes _____ | No_____ |
| Do you do self breast examinations? | Yes _____ | No_____ |
| Did you complete the Gardasil (HPV vaccine) series? | Yes _____ | No_____ |

Last mammogram ________________
Last colonoscopy ________________
Last bone density ________________
Last diabetes screening ________________
Last cholesterol screening ________________
Last thyroid screening ________________
Last pneumonia shot ________________
Are you in need of any vaccination updates, please indicate which ones here ________________

## Review of Systems

Please **circle** any of the following that apply to you:

Constitutional: Fever Weight gain Weight loss Fatigue
Integumentary: Change in moles Rashes Skin lesions
Breasts: Lumps Nipple discharge Skin change Abnormal mammogram
Cardiovascular: Chest pain Swelling Valve disorders
Gastrointestinal: Nausea Vomiting Bloating Diarrhea Constipation Blood in stool Black or tarry stool
Genitourinary: Burning or pain with urination Frequency Urgency Blood in urine Vaginal discharge Vaginal odor
Hematologic/Lymphatic: Blood clots Swollen lymph nodes Bruising easily
Endocrine: Excessive thirst Excessive hunger Excessive urination Hot flushes Cold intolerance Heat intolerance
Musculoskeletal: Joint pain Muscle pain Weakness
Neurological: Headaches Fainting Seizures
Psychiatric: Depression Anxiety Suicidal thoughts or plans
None of the above

# Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_______________ Patient Name:________________________________ Date of Birth: ______________

***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.***

| *PHQ-9* | 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 fidgety 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 in some way. | 0 | 1 | 2 | 3 |
| ***Add the score for each column*** | | | | |

**Total Score (add your column scores):** ______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.***

| *GAD-7* | Not at all sure | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge. | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying. | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things. | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing. | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still. | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable. | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen. | 0 | 1 | 2 | 3 |
| ***Add the score for each column*** | | | | |

**Total Score (add your column scores):** ______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**



Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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# Risk Assessment for Hereditary Cancer Syndrome

Patient Name: ______________________ Today's Date: ______________

Your Physician: ______________________ Date Of Birth: ______________

INSTRUCTIONS: Please circle YES (Y) to any statement below if it applies to **YOU or YOUR FAMILY MEMBERS.**
Next to each statement, please list the **AGE** of the person when they were **DIAGNOSED** with cancer and your relation.
**1st Degree Relatives** = Mother / Father / Sister / Brother / Children
**AND 2nd Degree Relatives** = Aunt / Uncle / Grandparent / Niece / Nephew
**AND 3rd Degree Relatives** = Great Grandparents / Great Aunts & Uncles / 1st Cousins

## 1. Have you had Genetic Testing Before?

| | | |
|---|---|---|
| ☐ **YES** | **Year you were tested?**__________ | **Result?** ☐ Positive ☐ Negative ☐ Unknown |
| ☐ **NO** | Proceed to Section 2 – Cancer History | |

| **2.** Yes/No | | **CANCER HISTORY** | **SELF SIBLINGS CHILDREN** | **MOTHER'S SIDE** | **FATHER'S SIDE** | **Age of** Diagnosis |
|---|---|---|---|---|---|---|
| **Y** | **N** | **Ovarian cancer** at any age | | | | |
| **Y** | **N** | **Breast Cancer** at 50 or younger | | | | |
| **Y** | **N** | **Bilateral Breast cancer** at any age | | | | |
| **Y** | **N** | **THREE OR MORE** relatives on the same side of the family with **Breast** cancer at any age | | | | |
| **Y** | **N** | **Male breast cancer** at any age | | | | |
| **Y** | **N** | **Pancreatic cancer** at any age | | | | |
| **Y** | **N** | **Ashkenazi Jewish ancestry** with **breast cancer** at any age | | | | |
| **Y** | **N** | **Colon** cancer **before age 50** | | | | |
| **Y** | **N** | **Endometrial/Uterine** cancer **before age 50** | | | | |
| **Y** | **N** | **THREE OR MORE** relatives on the same side the family with a **Colon/rectal and/or endometrial (uterine)** cancer at any age | | | | |
| **Y** | **N** | Have **YOU** ever had **Endometrial/Uterine** cancer | | — | — | |

FOR OFFICE USE ONLY:

Did patient meet criteria for Genetic Education? ◻ **YES** ◻ **NO** ◻ **MORE INFORMATION NEEDED**

If YES, Patient chose to: ◻ **ACCEPT** ◻ **DECLINE High Risk Education Program:** Reason______________________

If ACCEPTED, Patient: ◻ **SUBMITTED** a Sample to Myriad ◻ **DECLINED Testing:** Reason______________________

***PATIENT SIGNATURE:*** ______________________ **Date:**______________

***Provider SIGNATURE:*** ______________________

*Live Well in WNC*

**Telephone Consumer Protection Act (TCPA) Written Consent Form**

I authorize Live Well in WNC to deliver or cause to be delivered the following types of messages by voice call, text message, or email using an automatic telephone dialing system or an artificial or prerecorded voice:

-Appointment reminders

-Collection of payment/outstanding payment

-Notice of office hours updates/closures

I authorize this contact through any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Contact may also include text messages or emails, using any email address I have provided. I understand that I am not required to sign this document in order to receive services from Live Well in WNC.

_________________________________ ____________

Signature Date

_________________________________

Printed Name

# Live Well in WNC

PLEASE READ BELOW AND INITIAL IN THE APPROPRIATE SPACE

*By initialing, you agree that you have read and understand the importance of all sections. I understand that this information will become invalid after 1 year of date signed.*

## AUTHORIZATION FOR TREATMENT:

I HEREBY CONSENT TO MEDICAL TREATMENT, DIAGNOSTIC PROCEDURES, AND INJECTIONS BY THE PROVIDERS AND STAFF OF LIVE WELL IN WNC. I UNDERSTAND THAT DIAGNOSTIC PROCEDURES MAY INCLUDE, BUT ARE NOT LIMITED TO, LAB TESTS ON BLOOD, URINE, AND TISSUE. I UNDERSTAND THAT I MAY BE ASKED TO UNDERGO DIAGNOSTIC RADIOLOGY PROCEDURES INCLUDING, BUT NOT LIMITED TO, ULTRASOUNDS. I UNDERSTAND THAT I HAVE THE RIGHT TO ASK QUESTIONS ABOUT MY TREATMENT AND/OR PROCEDURES AND I AGREE TO NOTIFY MY PROVIDER OF MY CONCERNS.

______ INITIALS

### Important information regarding your specimen sent out from the office.

Live Well in WNC is in agreement to send all Pap smear and biopsy specimens to Quest Lab. Please be aware that Quest does bill separately for processing your specimen. Live Well in WNC is not affiliated with Quest Lab, we are two separate companies. It is your responsibility to be aware of your insurance benefits and to know if they are in your network.

______ INITIALS

### Appointment Policy

We understand that sometimes your day may not go as planned and you may be late or miss your appointment with us. Patients will be asked to give at least 24 hrs notice for any appointment cancellations. This is to give other patients the opportunity to be scheduled in that time slot. We also have a 10 minute window for established patient late appointments. If you are more than 10 minutes late for your scheduled appointment time you may be asked to reschedule. In the event that not keeping your appointments becomes an issue, patients may be dismissed from the practice. There is no window for new patient late appointments.

______INITIALS

### Financial Policy

By initialing here you are consenting that you understand that payment is due at the time or service. This includes copays, self pay patients and all hormone replacement and elective services.

______INITIALS

### Code of Conduct

Lice Well in WNC takes pride in personal care. We aim to treat all of our patients with respect and dignity at all times. We also expect the same from our patients. Angry outbursts, aggressive or violent type behavior, or inappropriate language will not be tolerated. Failure to comply with this may result in termination of our patient-physician relationship.

______INITIALS

### Prescription Refills

We strive to refill any medication requests within 48 hours of receiving the initial request; however refill requests that are initiated by the patient or the pharmacy after 4:00pm or on Fridays may not be refilled within that time frame.

______INITIALS

Patient Name (printed): ______________________________

Patient Signature: ______________________________ Date: ______________________

Parent/ Guardian Signature: ______________________________