

ATIGA FAMILY PRACTICE

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO OTHERS

Patients Name: _____

DOB: _____

I give permission for Atiga Family Practice to provide my personal health information checked below

- Scheduling/Appointment information
- Medical information, including symptoms, diagnosis, medications, and treatment plan
- Health information, including symptoms, diagnosis, medications, and treatment plan regarding (* items below must be checked, or this information cannot be given);
 - Substance abuse
 - Behavioral health
 - Developmental disability
 - HIV/AIDS
- Lab/Test results
- Billing and payment information
- All health information (* Protected health information items must be checked to give this information)

to the below named individuals/companies:

Name: _____	Relation to patient: _____
Name: _____	Relation to patient: _____
Name: _____	Relation to patient: _____
Name: _____	Relation to patient: _____

Authorization expires one year from the date of signature unless an alternate date is given.

Alternate date of expiration: _____

- I understand that my signature is required to release my personal information, to include photo identification, social security number, insurance information, demographics and medical history and treatment to others except in those circumstances where Atiga Family Practice is permitted or required by law to release this information. For example, Atiga Family Practice may release copies of this information to other health care providers, health plans, governmental agencies, and workers compensation carriers. Additionally, I understand that Atiga Family Practice is required by law to report certain diagnosis to the California Department of Public Health such as seizures, cancer, and the diagnosis of a communicable disease(s).
- I understand that this permission will remain in effect until the date stated above or until such time as I *revoke it in writing* (an updated agreement form will also revoke the validity of this specific agreement).

Patient/Authorized Representative Signature

Date

If other than patient signing, state relationship: _____

By checking this box, I agree that I am electronically signing this document.

By checking this box, I agree that I have reviewed this document, but prefer to sign the document manually vs electronically.

ANNUAL ADULT HEALTH HISTORY UPDATE

Name/Nombre:	Age/Edad:	DOB/Fecha de Nacimiento:	Today's Date/Fecha:
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Medical Diagnosis/Diagnóstico Médico

Have you been diagnosed with any new conditions since your last office visit?/ No

¿Le han diagnosticado alguna afección nueva desde su última visita al consultorio?

If yes, please list the date, diagnosis, and the provider or medical group who diagnosed you/

En caso afirmativo, indique la fecha, el diagnóstico y el proveedor o grupo médico que le diagnosticó:

Date of Diagnosis/ Fecha de diagnóstico	Diagnosis/Diagnóstico	Provider/Medical Group Name Nombre del proveedor/grupo médico

Surgeries/Cirugías

Have you had any surgeries since your last office visit? No

¿Ha tenido alguna cirugía desde su última visita al consultorio?

If yes, please list the date, surgery, and the name of the provider or medical group who performed it/

En caso afirmativo, indique la fecha, la cirugía y el nombre del proveedor o grupo médico que la realizó:

Date of Surgery/ Fecha de la cirugía	Surgery/Cirugía	Provider/Medical Group Name Nombre del proveedor/grupo médico

Hospitalizations/Hospitalizaciones

Have you been hospitalized (admitted as an inpatient) since your last office visit? No

¿Ha sido hospitalizado (admitido como paciente hospitalizado) en algún hospital desde su última visita al consultorio?

If yes, please list the dates you were admitted, the reason, and the name of the hospital/

En caso afirmativo, indique las fechas en que fue admitido, el motivo y el nombre del hospital:

Dates of Stay / Fechas de estancia	Reason for Hospitalization/ Motivo de la hospitalización	Name of Hospital/ Nombre del Hospital

Vaccinations/ Vacunas

Have you received any of the below vaccines since your last office visit? / No

¿Ha recibido alguna de las siguientes vacunas desde su última visita al consultorio?

Covid-19 ___/___/___ Flu/ Gripe ___/___/___ Pneumonia/ Pneumonia ___/___/___
 Shingles/ Herpes ___/___/___ Tetanus/ Tétanos ___/___/___ HPV/VPH: ___/___/___

ANNUAL ADULT HEALTH HISTORY UPDATE CONTINUED

Name/Nombre:	DOB/Fecha de Nacimiento:
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Screenings/Proyecciones

Have you completed any of the below health screenings since your last office visit? No

¿Ha completado alguno de los siguientes exámenes de salud desde su última visita al consultorio?

*If yes, please list the date completed and the provider or medical group who performed/
En caso afirmativo, indique la fecha de finalización y el proveedor o grupo médico que realizó:*

	Dates Completed/ Fechas de finalización	Where/Who Performed/ Dónde/Quién actuó
Eye Exam/Examen de la vista		
Colonoscopy/Colonoscopia		
Stool Test/Prueba de sangre oculta en heces		
Bone Density Scan/Gammagrafía de densidad ósea		
Skin Check/ Revisión de la piel		
Prostate Exam/Examen de próstata		

Family History/ Historia familiar

Have any family members been diagnosed with the below since your last office visit? / None, /Nada

¿Algún miembro de la familia ha sido diagnosticado con lo siguiente desde su última visita al consultorio?

If yes, please list which family member /En caso afirmativo, indique qué miembro de la familia

Diabetes	
High Blood Pressure/Presión arterial alta	
Heart Disease/ Cardiopatía	
Stroke/ Carrera	
Mental Illness/ Enfermedad mental	
Cancer (Also list type/También tipo de lista)	

Social History/ Historia social:

Married/ Casado Single/ Solero Separated/ Separado Divorced/ Dicoiciado Widowed/ Viudo

Occupation/ Ocupación: _____

Years of education/ Años de educación: _____

Housing/ Alojamiento: Homeless/ Sin hogar Apartment or Condo Mobile Home/ Casa móvil
 RV/ Vehículo recreacional House/ Casa Assisted living/ Vida asistida
 Skilled Nursing/ Enfermería especializada Residential care/ Atención residencial
 Live alone/ Vivir solo Live with family or friends/ Vivir con familiares o amigos

Do you have children living with you?/ ¿Tiene hijos viviendo con usted? Yes/ Sí No How many? _____

Caffeine Use/Consumo de cafeína:

Never/Nunca Rarely /Raramente Moderate/Moderado Amount/Day/ Cantidad/Día: _____

Name/Nombre:	DOB/Fecha de Nacimiento:
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Drug Use/Consumo de drogas: Type Used/Tipo utilizado: _____
 Never/Nunca Rarely /Raramente Occasional /Ocasional Daily, Amount: _____
 Diario, Cantidad


Sexual Activity/ Actividad sexual:

Have you had sex in the past 12 months? / ¿Ha tenido relaciones sexuales en los últimos 12 meses?
 Yes/ Sí No- skip to next section/ pasar a la siguiente sección
 Do you use birth control? / ¿Usas anticonceptivos? Yes/ Sí No
 If yes, what type?/ Si es así, ¿de qué tipo? Condoms/ Condones Oral contraceptives/ Anticonceptivos orales
 IUD/ DIU Implant Shot/ Inyección Vaginal ring/ Anillo vaginal Spermicide/ Espermicida
 Withdraw/ Retirar Other (list)/ Otra (lista): _____

Safety/ Seguridad:

Do you need assistance with any of the following? / ¿Necesita ayuda con alguno de los siguientes? No
 Bathing/ Baños Dressing/ Vendaje Eating/ Comiendo
 Getting from bed to chair/ Ir de la cama a la silla Toileting/ Aseo
 Do you have urinary and/or bowel incontinence? / ¿Tiene incontinencia urinaria y / o intestinal? Yes/ Sí No
 Do you use any of the following? / ¿Utiliza alguno de los siguientes? No
 Cane/Caña Walker/ Caminante Scooter Hospital bed/ Cama Oxygen/ Oxígeno
 Wheelchair/Silla de ruedasde hospital Nighttime breathing device/ Dispositivo de respiración nocturna

Do you have any new concerns you would like to discuss with your provider today? No

Patient Signature/ Firma del paciente _____ 

By checking this box, I agree that I am electronically signing this document. /
 Al marcar esta casilla, acepto que estoy firmando electrónicamente este documento.

By checking this box, I agree that I have reviewed this document, but prefer to sign the document manually vs electronically./
 Al marcar esta casilla, acepto que he revisado este documento, pero prefiero firmarlo manualmente en lugar de hacerlo electrónicamente.

Provider Signature/ Firma del proveedor _____

Periodic TB Risk Assessment

Patient Name: _____ DOB: _____ Today's Date: _____

TB SYMPTOM REVIEW:

- | Do you currently have any of the following symptoms? | YES | NO |
|--|-----------------------|-----------------------|
| 1. Cough that has lasted more than 3 weeks? | <input type="radio"/> | <input type="radio"/> |
| 2. Coughing up blood? | <input type="radio"/> | <input type="radio"/> |
| 3. Unexplained weight loss? | <input type="radio"/> | <input type="radio"/> |
| 4. Chronic Fever? | <input type="radio"/> | <input type="radio"/> |
| 5. Drenching night sweats? | <input type="radio"/> | <input type="radio"/> |

(IMMEDIATE CXR AND MEDICAL EVALUATION IS NEEDED IF THE ANSWER IS YES TO ANY OF THE ABOVE)

NEW TB MEDICAL RISKS FOR TB DISEASE PROGRESSION:

- | Since your last office visit do you have a NEW diagnosis of: | YES | NO |
|--|-----------------------|-----------------------|
| 1. HIV? | <input type="radio"/> | <input type="radio"/> |
| 2. Diabetes? | <input type="radio"/> | <input type="radio"/> |
| 3. Cancer? | <input type="radio"/> | <input type="radio"/> |
| 4. Kidney Failure? | <input type="radio"/> | <input type="radio"/> |

OR have you started taking any of the following IMMUNOSUPPRESSIVE MEDICATIONS:

- | | | |
|---|-----------------------|-----------------------|
| 1. Prednisone? | <input type="radio"/> | <input type="radio"/> |
| 2. Methotrexate? | <input type="radio"/> | <input type="radio"/> |
| 3. Cyclosporine? | <input type="radio"/> | <input type="radio"/> |
| 4. Chemotherapy? | <input type="radio"/> | <input type="radio"/> |
| 5. IV rheumatoid, psoriatic arthritis or Chron's disease medications? | <input type="radio"/> | <input type="radio"/> |

NEW TB EXPOSURE RISK:

- | In the past 2 years ... | YES | NO |
|---|-----------------------|-----------------------|
| 1. Have you had contact with anyone with known TB disease? | <input type="radio"/> | <input type="radio"/> |
| 2. Have you spent more than 2 weeks in Asia, Africa, Latin America or Eastern Europe? | <input type="radio"/> | <input type="radio"/> |
| 3. Have you been incarcerated in either prison or jail? | <input type="radio"/> | <input type="radio"/> |
| 4. Have you been homeless or living in a single room occupancy hotel? | <input type="radio"/> | <input type="radio"/> |
| 5. Have you injected street drugs? | <input type="radio"/> | <input type="radio"/> |
| 6. Have you worked with homeless persons, migrant workers or drug users? | <input type="radio"/> | <input type="radio"/> |
| 7. Have you worked as a health care worker? | <input type="radio"/> | <input type="radio"/> |

New or repeat TB test (Mantoux or blood test) is needed if the answer is YES to ANY of the above questions

REQUIRED: Document the patients Mantoux or blood test results in the medical record and database.

Provider Signature: _____

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date
Person Completing Form <i>(if patient needs help)</i>	<input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Other <i>Please specify:</i>		Need help with form? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
Clinic Use Only:

1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?				Nutrition
2	Do you eat fruits and vegetables every day?				
3	Do you limit the amount of fried food or fast food that you eat?				
4	Are you easily able to get enough healthy food?				
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?				
6	Do you often eat too much or too little food?				
7	Do you have difficulty chewing or swallowing?				
8	Are you concerned about your weight?				
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?				Physical Activity
10	Do you feel safe where you live?				Safety
11	Do you often have trouble keeping track of your medicines?				
12	Are family members or friends worried about your driving?				
13	Have you had any car accidents lately?				
14	Do you sometimes fall and hurt yourself, or is it hard to get up?				
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?				
16	Do you keep a gun in your house or place where you live?				Dental Health
17	Do you brush and floss your teeth daily?				
18	Do you often feel sad, hopeless, angry, or worried?				Mental Health
19	Do you often have trouble sleeping?				

Name: _____

DOB: _____

20	Do you or others think that you are having trouble remembering things?				
21	Do you smoke or chew tobacco?				Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?				
23	In the past year, have you had 4 or more alcohol drinks in one day?				
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?				
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?				Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?				
27	Have you or your partner(s) had sex without a condom in the past year?				
28	Have you ever been forced or pressured to have sex?				
29	Do you have someone to help you make decisions about your health and medical care?				Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?				
31	Do you have someone to call when you need help in an emergency?				
32	Do you have other questions or concerns about your health?				Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Independent Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PCP's Signature: _____ Print Name: _____ Date: _____

SHA ANNUAL REVIEW

PCP's Signature: _____ Print Name: _____ Date: _____

PCP's Signature: _____ Print Name: _____ Date: _____

PCP's Signature: _____ Print Name: _____ Date: _____

PCP's Signature: _____ Print Name: _____ Date: _____

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: _____

DOB: _____

Date of Referral: _____

PHQ9		0	1	2	3
Over the last two weeks how often have you been bothered by the following problems?		Not at all	Several Days	More than half the days	Nearly every day
A	Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C	Trouble falling or staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D	Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I	Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
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

GAD7		0	1	2	3
Over the last two weeks how often have you been bothered by the following problems?		Not at all	Several Days	Over than half the days	Nearly every day
Feeling nervous, anxious, or on edge		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it's hard to sit still		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Score (add your column scores)					
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

Providers signature: _____

Date: _____