



**FAMILIES FIRST
MEDICAL GROUP**

11555 Central Parkway, Suite #402, Jacksonville, FL 32224

Phone: (904) 747-3800 Fax: (904) 747-3788

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Date: _____

Patient's Full Legal Name _____

Nickname or name patient goes by _____

Social Security # _____ DOB _____ Age _____

Address _____

City, State, Zip _____

Home Phone # _____ Cell Phone # _____

Email Address _____

Driver's License # _____

Gender: Male Female Marital Status: Single Engaged Married Divorced

Spouse/ Other Name/ Age: _____

Name(s)/ Age(s) of children _____

Employer _____ **Occupation** _____

Business Address _____

City, State, Zip _____ Work Phone # _____

Who may we thank for referring you to our office? _____

In case of emergency,
who should be notified? _____ Relationship to patient _____

Insurance Information (Primary coverage)

Name of Person Holding Policy _____

Relationship to Patient _____

Insurance Co. Name _____ Policy # _____

Address _____ Group # _____

Address con't _____ Phone # _____

City, State, Zip _____ Effective date coverage began _____

Insurance Information (Secondary - if applicable)

Name of Person Holding Policy _____

Relationship to Patient _____

Insurance Co. Name _____ Policy # _____

Address _____ Group # _____

Address con't _____ Phone # _____

City, State, ZIP _____ Effective date coverage began _____

Insurance Assignment and Release

I, the undersigned, certify that I have insurance coverage with _____
(Name of Insurance Company)

and assign directly to FAMILIES FIRST MEDICAL GROUP insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the providers to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

Medical and Family History Form

Date of Last Annual Wellness Exam: _____

Most important concerns for this visit:

1. _____

2. _____

ALLERGIES to Medication(s): Yes (detail below) No Known Drug Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other Allergies (please list): _____

MEDICATIONS: Please list all prescription medications, over-the-counter medications, vitamins, and other supplements you are currently taking:

	Medication Name	Dose (mg)	Type (tablet, cream, IV)	How Often?
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Please indicate if you have had any of the following screening tests, and the most recent date:

Colonoscopy: _____ DEXA (bone density): _____ Women: Pap: _____ Mammogram: _____

Adult immunizations: It is very important for us to have the dates of your most recent immunizations. Please check with your previous provider for dates.

Tetanus Yes No Date: _____ Was pertussis included (Tdap)? Yes No

Pneumonia Yes No Date: _____ Zostavax Yes No Date: _____

Hepatitis B Yes No Dates (3 shots): _____

HPV Yes No Dates (3 shots): _____

CURRENT HEALTH SYMPTOMS

Please complete all questions:

1. Have you had a recent weight gain or loss that worries you? Yes No
2. Have you had any unexplained fevers or night sweats? Yes No
3. Do you have sinus or nasal allergy symptoms that affect your quality of life? Yes No
4. Do you have any vision or hearing problems that are bothersome? Yes No
5. Are you experiencing chest pains or irregular beats that worry you? Yes No
6. Do you have unusual shortness of breath or a persistent cough? Yes No
7. Do you have leg swelling that is recurrent or bothersome? Yes No
8. Do you experience wheezing when you breathe? Yes No
9. Do you have sleep problems that interferes with quality of life? Yes No
10. Have you been told that you snore and stop breathing during sleep? Yes No
11. Do you have constipation, diarrhea, stomach pain or other problems with digestion that interfere with your quality of life? Yes No
12. Have your bowel movement patterns changed in recent months? Yes No
13. Do you have problems with urination that affects quality of life? Yes No
14. Do you have problems with sexual function that affects quality of life? Yes No
15. Do you have joint or back problems that affect your quality of life? Yes No
16. Do you have leg pain, numbness or weakness that limits how fast or far you can walk? Yes No
17. Do you have headaches that affect your ability to function? Yes No
18. Have you had an unexpected fall with injury in the past year? Yes No
19. Do you have poor balance or fear of falling? Yes No
20. Do you have little pleasure in doing things? Yes No
21. Do you feel down, depressed, or hopeless? Yes No
22. Are you concerned about anxiety or stress in your life? Yes No
23. Are you concerned about your memory? Yes No
24. Have you noticed unusual bruising or bleeding? Yes No
25. Do you have unusual skin lesions that concern you? Yes No

Comments: _____

* Note: Evaluation of these concerns is not usually part of an annual wellness or preventative exam. It is likely that your doctor will need to schedule extra time or an additional appointment to follow up on these problems.

*Patient initials _____

CONSENT FOR MEDICAL TREATMENT

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1. **CONSENT FOR HEALTH CARE SERVICES.** I authorize physician(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at FAMILIES FIRST MEDICAL GROUP. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the Kids & Families Medical Clinic may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered by the practice.

2. **KIDS & FAMILIES MEDICAL CLINIC PRACTITIONERS.** I understand that I may receive services from professionals who provide care to me who are not employees or agents of All About Kids & Families. These professionals may include other physicians requested by my physician to participate in my care as well as radiology, pathology and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from All About Kids & Families. I understand that, in some cases, these non FAMILIES FIRST MEDICAL GROUP Clinic professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.

3. **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

4. **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service. Any remaining charges are due upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide to the practice or any entity to which the practice assigns my account, as well as the use of technology including auto-dialing and/or prerecorded messages in contacting me.

All official FAMILIES FIRST MEDICAL GROUP policies are maintained electronically and are subject to change. No printed policy should be taken as the official policy except to the extent it is consistent with the FAMILIES FIRST MEDICAL GROUP policy that is electronically maintained.

CONSENT FOR MEDICAL TREATMENT

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5. PREAUTHORIZATION REQUIREMENTS. I understand that it is my sole responsibility to verify that all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice’s and physicians’ charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

6. ASSIGNMENT FOR DIRECT PAYMENT. I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.

7. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that FAMILIES FIRST MEDICAL GROUP has offered me a copy of its Notice of Privacy Practices.

By checking one of the boxes below, I acknowledge:

- I have been offered or accepted a copy of the Notice of Privacy Practices
- I declined a copy of the Notice of Privacy Practices

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

ADDRESS OF PATIENT

All official FAMILIES FIRST MEDICAL GROUP policies are maintained electronically and are subject to change. No printed policy should be taken as the official policy except to the extent it is consistent with the FAMILIES FIRST MEDICAL GROUP policy that is electronically maintained.

CLASSIFICATION OF ETHNICITY & RACE

Providing you with the very best care is our highest consideration. In order do that, it will help us to know a little bit about you.

While most diseases cross all ethnic/racial and gender boundaries, there are certain disease processes that are more likely to occur in a certain race or gender. In fact, some people may have different symptoms, or respond differently to treatments, because of these factors.

For that reason, we would like for you to share some information with us about your race/ethnicity. Sharing this information is entirely optional, but we believe it will assist our physicians and other care-givers in serving you best. It will not be used as a basis to deny or otherwise restrict the health care services you receive. Please consider the information below. Thank you.

Ethnicity

Do you consider yourself to be Hispanic or Latino according to the definition below?

(Choose only one)

- Yes, I am Hispanic or Latino**---A person of Mexican, Puerto Rican, Cuban, Central American, South American, or other Spanish culture or origin, regardless of race
- No, I am not Hispanic or Latino**

Race

What race do you consider yourself to be?

- American Indian or Alaska Native**---A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliation or community attachment
- Asian**---A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- Black or African American**---A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or other Pacific Islander**---A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White**---A person having origins in any of the original peoples of Europe, the Middle East, or North Africa
- Refuse to provide information**--- I do not wish to provide some or all of the above information
- More Than One Race** Please list: _____



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FINANCIAL POLICY

Your understanding of our FINANCIAL POLICY is important to us. Please let us know if have any questions about our fees, financial policy or your responsibilities.

* CO-PAY, CO-INSURANCE, DEDUCTIBLES AND BALANCES ARE DUE AT THE TIME OF SERVICE

* WE ACCEPT CASH, VISA, MASTERCARD & DISCOVER

* NO SHOW FEE: 24 hour notice for cancellation must be given or there will be a \$25.00 no show fee added to your account.

* BILLING

FAMILIES FIRST MEDICAL GROUP does not bill or extend credit. You are required to pay your co- pay, deductible, or any balance due at the time of service. We cannot hold checks. If you have an emergency situation or an issue that will prevent you from paying for your service, please contact our billing department in advance and they will discuss arrangements with you.

* INSURANCE

If we accept your insurance, you are responsible for any deductibles, co-insurance or co-pays at the time of service. IF YOUR INSURANCE CARRIER CHANGES, IT IS YOUR RESPONSIBILITY TO NOTIFY US WHEN CHECKING IN. IF YOU FAIL TO DO SO, YOU MAY BECOME RESPONSIBLE FOR THE FULL AMOUNT OF THE VISIT.

Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company. You are responsible for the timely payment of your account.

* I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered, not covered by insurance. I have read all of the information above and understand it to the best of my knowledge. I will notify you of any and all future changes.

Signature of Patient _____ Date _____

PRIVACY POLICY

INTRODUCTION

FAMILIES FIRST MEDICAL GROUP is committed to protecting the privacy of our patients. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), FAMILIES FIRST MEDICAL GROUP has created a Privacy Policy. The purpose of this notification is to familiarize you with the existence of our policy, as well as give you an overview of its contents. The full written policy is available to you on request.

HIGHLIGHTS

Your Rights: You have a right to inspect and copy your protected health information. You have a right to request a restriction of your protected health information. You have the right to have your physician amend your health information. You have a right to receive an accounting of disclosures of your protected health information.

FAMILIES FIRST MEDICAL GROUP will use your private information in a variety of ways to facilitate your care. Some of these uses require your written consent and some do not. Private information (termed Protected Health Information or PHI in HIPPA), includes anything which individually might identify you (Name, SSN, diagnoses, etc.)

FAMILIES FIRST MEDICAL GROUP Clinic may use your PHI without written consent to communicate with emergency rooms, hospitals, specialists, lab and x-ray facilities, and other facilities involved in the current treatment of the patient. In addition, FAMILIES FIRST MEDICAL GROUP will routinely use PHI in the submission of billing to insurance companies. Also, any release required by law (mandatory notification of contagious disease to the health department, issues involving abuse or neglect, adverse drug and treatment reports to the FDA, issues involving criminal activity to law enforcement, or other releases required by law) may take place.

FAMILIES FIRST MEDICAL GROUP requires your written consent to release PHI to parties other than those listed above. This includes release to relatives other than immediate caregivers, to attorneys, to employers, to life insurance or disability insurance carriers, to research projects, or any others not listed previously.

FAMILIES FIRST MEDICAL GROUP does have business relationships with some companies who might periodically have access to your PHI. These include our attorneys, practice management consultants, computer system consultants and others. The purpose of these situations is for these entities to advise us, internally, on our practice operations. Kids & Families Medical Clinic maintains a contractual agreement with these entities which restricts their use of private information to their business relationship with us.

FAMILIES FIRST MEDICAL GROUP does increasingly use computer systems to transmit private information. This is largely to transmit claim and referral information with insurers and to exchange private information with other health care facilities. HIPPA mandates the secure electronic transmission of private information and we are in compliance with those requirements.

FAMILIES FIRST MEDICAL GROUP does use PHI during the day to day operations of the office. While certain uses of PHI (such as calling you by name in the waiting room) are acceptable, others (such as a person overhearing a telephone call regarding your case) are not. We are committed to preventing inadvertent disclosures. Your feedback about how we are doing in this or any other area is strongly encouraged.

Signed by Patient / Guardian: _____ Date: _____



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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE**

Patient Name _____ Patient SS# _____ DOB _____

Patient's Address _____

I hereby authorize FAMILIES FIRST MEDICAL GROUP to (please check one of the following):

Obtain copies of my medical record (s) from: **Release copies of my medical record (s) to:**

Name _____

Address _____

Phone Number _____ Fax Number _____

Information as identified below is to be released:(*check all that apply*)

- | | | |
|---|--|---|
| <input type="checkbox"/> All Medical Records * | <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Mental/Behavioral Health Notes |
| <input type="checkbox"/> Progress Sheets/Clinic Notes | <input type="checkbox"/> Cardiac Rehab | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Doctors Orders | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Pulmonary Rehab |
| <input type="checkbox"/> Lab/Pathology Report | <input type="checkbox"/> Occupational Health | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> PT/OT/ST | <input type="checkbox"/> Psychological Report | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Other _____ |

All records pertaining to psychiatric/mental health, chemical dependency and/or communicable diseases (*if any such information exists*), may be released unless otherwise specified above.

*This information is needed for the following purpose(s): _____

HIPAA Privacy Rule. I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above.

This authorization will automatically expire ninety (90) days following the date of signature.

I acknowledge that I have read and understand this authorization and its content.

Signature of Patient _____ Date _____

Signature of Parent or Legal Guardian _____ Date _____

Prohibition of Disclosure: Federal Law (42 CFR Part 2) and HIPAA 1996 prohibit further disclosure of this information except with written consent from the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

Witness _____ (Staff Name) Date _____

Past Medical History:

Please review the list below and check any conditions you have had now or in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Eczema | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Frequent UTI's | <input type="checkbox"/> Positive TB Skin Test |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Freq Sinus Infections | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Reflux (heartburn) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Heart Condition (specify) | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis (specify A, B, C) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer (What kind) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Trans. Disease |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> (specify) |
| <input type="checkbox"/> Crohn's Disease or IBS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Melanoma or Skin Cancer | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Migraines | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Osteoarthritis | |

Other medical problem(s) not on this list: _____

Please check or list any **SURGERIES** you have had:

Type of surgery:	Year	Type of surgery:	Year
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Arthroscopy (joint)	_____	<input type="checkbox"/> Knee or Hip Replacement	_____
<input type="checkbox"/> Back or Neck Surgery	_____	<input type="checkbox"/> Mastectomy or Lumpectomy	_____
<input type="checkbox"/> Cataract Surgery	_____	<input type="checkbox"/> Mastectomy/Lumpectomy	_____
<input type="checkbox"/> Cesarean Section	_____	<input type="checkbox"/> Polyp Removal (colon)	_____
<input type="checkbox"/> Gallbladder Removal	_____	<input type="checkbox"/> Tonsillectomy/Adenoidectomy	_____
<input type="checkbox"/> Heart Surgery (specify)	_____	<input type="checkbox"/> Tubal Ligation or Vasectomy	_____
<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Plastic Surgery (specify)	_____
<input type="checkbox"/> Hernia	_____	<input type="checkbox"/> Other (specify)	_____

Please list all previous **HOSPITALIZATIONS:**

Reason for hospitalization:	Date
_____	_____
_____	_____
_____	_____
_____	_____

For Women:

Last menstrual period _____

Last pap smear _____

Last mammogram _____

Last bone density _____

Age of first period _____

of days in cycle _____

of days in flow _____

Are you menopausal Y N

Age at onset of menopause _____

of pregnancies _____

of live births _____

of miscarriages _____

of abortions _____

of living children _____

Family Health History:

Have any of your family members had any of the following health problems?

Condition:	Family Member:	Condition:	Family Member:
<input type="checkbox"/> Heart Disease/attack	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Breast Cancer	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Colon Cancer	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Prostate Cancer	_____
<input type="checkbox"/> Thyroid Disease	_____	<input type="checkbox"/> Lung Cancer	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Ovarian Cancer	_____
<input type="checkbox"/> Other Mental Illness	_____	<input type="checkbox"/> Uterine Cancer	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Skin Cancer	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Other Cancer	_____

Any other illness in the family not listed? _____

Mother's Health Condition(s): _____

Living? Y/N If no, age at death _____

Father's Health Condition(s): _____

Living? Y/N If no, age at death _____

Sibling's Health Condition(s): _____

Other: _____

Health Habits:

1. Do you smoke currently? Yes No

If yes, how much? # of cigarettes per day _____ # of years smoking _____

If no, did you smoke in the past? Yes No How many years? _____ How much? # of packs per day _____

Are you exposed to smoke? Yes No

Any other tobacco use? Yes No Type: Cigars Chewing Tobacco Snuff Other

2. Do you drink caffeine? Yes No If so, how much?

3. Do you drink alcohol? Yes No What kind? Beer Wine Liquor Other: _____

If so, how many times per week? _____ month? _____ year? _____

Have you ever had a problem with alcohol in the past? (legal or social) Yes No

4. Have you ever used street drugs? Yes No

Which ones? Marijuana IV drugs Amphetamines Cocaine Heroin Downers Inhalants

Other _____

Are you still using? Yes No Which ones? _____

5. Are you sexually active (in the last year)? Yes No

If yes, circle all that apply: 1 partner multiple partners Male partner(s) Female partner(s)

Which birth control do you or your partner use? None Condoms Pill Vasectomy/tubal

Other _____

6. Do you exercise? Yes No If so, what type and how often? _____

7. Do you eat out at restaurants weekly? Yes No Times per week _____

8. How many servings of fruits and vegetables do you get per day? 0 1 2 3 4 5 >5

9. Do you take a calcium supplement? Yes No Number of dairy servings per day: _____ (e.g. milk, cheese)

10. Do you wear a seatbelt while in a vehicle? Yes No

11. Do you have a living will (do not resuscitate, medical power of attorney)? Yes No

If no, would you like information? Yes No

12. Is there concern for your safety (emotional, physical, or sexual abuse)? Yes No

13. Do you feel safe at home? Yes No