DOCTORS' VOLUNTEER CLINIC

PATIENT INFORMATION

TODAY'S DATE: _____/_____/_____

Last Name:

First Name:

Middle Name:

Date of Birth:

SSN#:

Address:

Zip Code:

City: **State:**

if patient is a minor, the information below will be the

parent or guardian's information

Emergency Contact:

Name:

Relationship:

Phone:

Race: Alaska Native: ☐

American Indian: ☐ Asian: ☐

African American/Black: ☐ Hawaiian: ☐

Pacific Islander: ☐ White: ☐

Other: ☐

Hispanic, Latino, Spanish? Yes: ☐ No: ☐

Marital Status: Single/Separated/Divorced: ☐

Married/Partner: ☐ Prefer not to say: ☐

How were you referred to us?

Self/Family/Friends: ☐ Emergency Room: ☐

Online: ☐ Court: ☐ Behavioral Medicine: ☐

Switchpoint: ☐ LDS: ☐ Family Healthcare: ☐

Other: _____

Home Phone:

Mobile Phone:

Consent to Text: Yes: ☐ No: ☐

Email:

Sex: Male: ☐ Female: ☐

Consent to leave voicemail with medical information?

Yes: ☐ No: ☐

Consent to discuss medical information with family?

Yes: ☐ No: ☐

If yes, who?

Family Size (circle one): 1 2 3 4 5 6 7 8 9

Monthly Household Income: $_____.00

US Citizen: Yes: ☐ No: ☐

Disabled: Yes: ☐ No: ☐

Highest Education Level: K12: ☐

High School/GED: ☐

Higher Education: ☐

Employment: Part Time: ☐

Full Time: ☐

Retired: ☐

Unemployed: ☐

Homeless: Yes: ☐ No: ☐

Insurance / Medicaid: Yes: ☐ No: ☐

If yes, what type?

Military Veteran: Yes: ☐ No: ☐

⇨SEE BACK SIDE⇦

The Doctors' Volunteer Clinic Patient Consent Form

Healthcare Providers at the Doctors' Volunteer Clinic do not receive any compensation or remuneration for providing services and are volunteering their time. Therefore, in accordance with the Utah Health Care Malpractice Act and Health Care Providers Immunity for Liability Act, *Section 58-133* , The Doctors' Volunteer Clinic is not liable for any civil damages for acts or omission except for those acts or omissions that are willful and wanton.

I have read and understand the above and give my consent to treatment and consent to waive any right to sue for professional negligence except for acts or omission which are grossly negligent or are willful and wanton.

Signature:_____ Date: _____

Declaration of Eligibility for Diagnostic Services Voucher

This form serves as documentation for the Doctors' Volunteer Clinic and Intermountain Healthcare to determine my eligibility for a Diagnostic Services Voucher to be used at an Intermountain Healthcare facility. I understand that if I am not eligible for a voucher I am expected to pay the full cost of the diagnostic services at the Intermountain Healthcare Facility. I understand that if I need help paying my bills, I can meet with an Intermountain Healthcare Eligibility Counselor.

I hereby state that the information given herein is true and correct. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services from Intermountain Healthcare.

Signature:_____ Date: _____

Health Information Exchange

A Health Information Exchange ("HIE") shares health information among participating doctors' offices, hospitals, diagnostic centers, pharmacies, and other health care providers through a secure, electronic means. The Doctors' Volunteer Clinic participates in the CommonWell/ Careequality Network. Your health care information is available to particpating healthcare providers where and when they need it for your care without delay. This allows your providers to have the benefit of your most recent health information from other participating providers who are taking care of you.

By signing, I affirm my approval for my data to be shared with providers at connected care locations and medication history with pharmacy benefit managers.

Signature:_____ Date: _____

DOCTORS' VOLUNTEER CLINIC

1036 E. Riverside Dr. St. George, UT 84790
Phone: 435.656.0022 Fax: 435.634.8166
Website: volunteerclinic.org

PATIENT HISTORY FORM

Date:_____/_____/_____

NAME: _____ Birthdate:_____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes
If yes please list:

Please list any medications that you are currently taking. Include non-prescription medications and vitamins/supplements:

Name of medication	Dose (include strength and number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

MEDICAL HISTORY

Do you currently have or were previously diagnosed with any of the following conditions?

- ☐ Alcohol/drug abuse
- ☐ Anemia
- ☐ Angina
- ☐ Asthma
- ☐ Cancer (type)_____
- ☐ Cataracts
- ☐ Colitis
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema (COPD)
- ☐ Epilepsy (seizures)
- ☐ Gallbladder disease
- ☐ Acid Reflux (Heartburn/GERD)
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Migraines
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Anxiety/Depression

☐ Other medical conditions (please list):

MEDICAL HISTORY (CONTINUED)

Have you ever been hospitalized? ❑ No ❑ Yes
If yes, please describe (include approximate date): _____

Have you had any serious injuries and/or broken bones? ❑ No ❑ Yes
If yes, please describe (include approximate date): _____

Have you ever received a blood transfusion? ❑ Unknown ❑ No ❑ Yes
If yes, please describe (include approximate date): _____

Have you received the following IMMUNIZATIONS?
If yes, indicate the approximate year it was last given
Pneumococcal (for pneumonia) ❑Unknown ❑No ❑Yes Year_____
Measles, Mumps, and Rubella (MMR) ❑Unknown ❑No ❑Yes Year_____
Hepatitis A ❑Unknown ❑No ❑Yes Year_____
Hepatitis B ❑Unknown ❑No ❑Yes Year_____
Tetanus/Diphtheria within last 10 years ❑ Unknown ❑No ❑ Yes Year_____
Polio ❑Unknown ❑No ❑Yes Year_____
Influenza (flu) ❑ Unknown ❑No ❑ Yes

FAMILY MEDICAL HISTORY

Do any of your immediate family members currently have or were previously diagnosed with any of the following conditions?

Condition	Family Member(s)
Alcohol/drug abuse	
Asthma	
Cancer (please list type)	
Depression/anxiety	
Diabetes	
Heart disease	
High blood pressure	
Stroke	
Other:	
Other:	
Other:	

SURGICAL HISTORY

Please list any previous surgical procedures and their approximate dates.

	Surgery/Procedure	Approximate Date
1.		
2.		
3.		
4.		
5.		

SOCIAL HISTORY

Have you ever used any of the following substances?

Substance	Current use?	Previous use?	Type/Amount/Frequency	How long? (years)	If stopped, when? (year)
Caffeine	❑ No ❑ Yes	❑ No ❑Yes			
Tobacco	❑ No ❑ Yes	❑ No ❑ Yes			
Alcohol	❑ No ❑ Yes	❑ No ❑ Yes			
Recreational drugs	❑ No ❑ Yes	❑ No ❑ Yes			

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 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

FOR OFFICE CODING 0 + _____ + _____ + _____

=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**
☐	☐	☐	☐