OPTUM®

Health assessment and insurance information

Please complete the following form and bring it with you to your first appointment. Your provider will need to review your health assessment with you. Or you may mail the completed form to us using the Optum address at the top of the welcome letter (the first page).

Thank you for choosing Optum. We look forward to caring for you.

General information

Primary language: _____

_____ _____ _____ _____ / _____ / _____

Patient last name | First name | MI | Date of birth

_____ –_____ –_____ _____ –_____ –_____

Home phone # | Cell phone #

_____

Home address | City | State | Zip

SS# _____-_____-_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

_____

Employer

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ White ☐ Latino
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Decline to answer

_____

Email Address

In addition to gaining access to the online health portal, I would like to receive occasional emails with information to help me better manage my health. ☐ Yes ☐ No

_____ _____

Primary insurance carrier | Policy ID

☐ HMO ☐ PPO ☐ POS ☐ Other _____ _____ –_____ –_____
(Type of plan) | Insurance carrier phone #

_____ _____

Secondary insurance carrier | Policy ID

☐ HMO ☐ PPO ☐ POS ☐ Other _____ _____ –_____ –_____
(Type of plan) | Insurance carrier phone #

Important: In case of emergency, who would we contact?

_____ _____

Name | Relationship

_____ _____ –_____ –_____

Address (Street/City/ZIP) | Home phone #

_____ _____ –_____ –_____

Cell phone # | Work #

"I understand that I am financially responsible for all charges, whether or not paid by insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give the clinic (Optum) consent to perform medical treatment."

Patient/Guardian (Signature) _____ Date _____ / _____ / _____

Patient/Guardian (Print name) _____

General information

_____ _____ _____ _____ / _____ / _____

Patient last name | First name | MI | Date of birth

The U.S. Department of Health and Human Services has included sexual orientation and gender identity in its data collection requirements. This information will assist providers with improving the health of their patient population by delivering patient-centered, culturally-competent care.

Birth sex: ☐ Male ☐ Female ☐ Ambiguous
(Gender assigned on your original birth certificate.)

Identify as: ☐ Male ☐ Female ☐ Male to female ☐ Female to male
(Current gender identity.) ☐ Other ☐ Decline

Preferred pronoun: ☐ Male (he, him, his) ☐ Female (she, her) ☐ Gender neutral (they, them, zie, zir)
(The pronoun or set of pronouns that you would like others to use when talking to or about you.)

Sexual orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unknown ☐ Other ☐ Decline
(The gender to which you are attracted.)

Patient medical history

Date of last physical exam: _____ Previous provider name: _____

Provider address: _____

Past history (personal and allergies): Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	CVA/TIA	☐	☐	Migraine headache	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Nervous breakdown	☐	☐
Alcohol overuse	☐	☐	Emphysema/COPD	☐	☐	Ostomies _____	☐	☐
Allergies	☐	☐	Falls	☐	☐	Paralysis	☐	☐
(other than medications)			Gallbladder disease	☐	☐	Rheumatic fever	☐	☐
Arthritis	☐	☐	Gout	☐	☐	Seizures	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐	Sexually		
Bleeding disorder	☐	☐	Heart attack/MI	☐	☐	transmitted diseases	☐	☐
Cancer	☐	☐	Other heart disease	☐	☐	Sickle cell anemia	☐	☐
location: _____			(CHF/CAD)			Sleep disorder	☐	☐
Cardiac arrhythmias	☐	☐	Hepatitis	☐	☐	Stomach ulcers	☐	☐
pacemaker:_____			High blood pressure	☐	☐	Thyroid disease	☐	☐
Chicken pox	☐	☐	Jaundice	☐	☐	Vascular disease	☐	☐
Colitis	☐	☐	Kidney disease	☐	☐			
Depression	☐	☐	Measles/Mumps	☐	☐			

Personal habits:

1. Have you ever smoked? ☐ Yes ☐ No If yes, are you are regular smoker now? ☐ Yes ☐ No
2. Have you used chewing tobacco? ☐ Yes ☐ No If yes, number of years _____
3. Do you regularly drink alcohol? ☐ Yes ☐ No If yes, how often? _____
4. Have you ever used any of the following? ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ Other

_____ _____ _____ _____ / _____ / _____

Patient last name | First name | MI | Date of birth

Operations: List and indicate approximate year.

_____

_____

_____

Serious injuries: List injuries and give approximate dates.

_____

_____

_____

Hospitalizations: (other than operations)
List reasons and approximate dates.

_____

_____

_____

Diagnostic tests/exams:

Last test/exam:	**Date:**	**Location/Provider:**
Eye exam:		
Foot exam:		

Immunizations: (Please give date) Hepatitis B _____ Flu _____ Polio _____

Typhoid _____ Smallpox _____ Tetanus _____ Pneumococcal _____ Chicken Pox _____

Family history	**If living**		**If deceased**	
	Age	Health: Good, Fair or Poor	Age at death	Cause
Father				
Mother				
Brother(s)				
Brother(s)				
Sister(s)				
Sister(s)				
Husband				
Wife				
Son(s)				
Daughter(s)				

Check if any blood relative has or had any of the following and enter their relationship:

	Yes	No	Relationship to you
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bleeding tendency	☐	☐	_____
Cancer	☐	☐	_____
Colitis	☐	☐	_____
Congenital heart disease	☐	☐	_____
Diabetes	☐	☐	_____
Emphysema	☐	☐	_____
Epilepsy	☐	☐	_____
Goiter	☐	☐	_____
Gout	☐	☐	_____
Hay fever	☐	☐	_____
Heart attack	☐	☐	_____

	Yes	No	Relationship to you
High blood pressure	☐	☐	_____
Intestinal polyps	☐	☐	_____
Kidney disease	☐	☐	_____
Leukemia	☐	☐	_____
Migraine	☐	☐	_____
Nervous breakdown	☐	☐	_____
Rheumatic fever	☐	☐	_____
Sickle cell anemia	☐	☐	_____
Stomach ulcers	☐	☐	_____
Stroke	☐	☐	_____
Suicide	☐	☐	_____
Tuberculosis	☐	☐	_____
Other	☐	☐	_____

Patient last name	First name	MI	Date of birth
_____	_____	_____	_____ / _____ / _____

Medications you currently take:

- ☐ Asthma/wheezing medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol or similar products
- ☐ Blood pressure pills
- ☐ Cortisone, Prednisone
- ☐ Cough medicine
- ☐ Digitalis or heart medicine
- ☐ Hormones
- ☐ Insulin or diabetic pills
- ☐ Anemia medications
- ☐ Laxatives
- ☐ Sleeping pills/tranquilizers
- ☐ Thyroid medicine
- ☐ Stomach/digestive medicine
- ☐ Weight-reducing pills
- ☐ Blood thinners or Coumadin
- ☐ Dilantin or seizure medications
- ☐ Water pills or diuretics
- ☐ Antibiotics
- ☐ Phenobarbital/barbiturates
- ☐ Vitamins
- ☐ Other prescription or over-the-counter drugs

Pharmacy name: _____

Pharmacy address: _____

Pharmacy phone number: _____

List each medication, its dosage and how often you take it, including vitamins and herbal supplements.

Medication	Dosage	How often?	When started?

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list medications and the reactions.

Medication	Reaction

Patient last name	First name	MI	Date of birth
_____	_____	_____	_____ / _____ / _____

Social/lifestyle history:

Is there someone that lives in your residence?	☐ Yes ☐ No	If yes, please list name and relationship:
Type of residence		☐ Apartment ☐ Mobile home ☐ House ☐ One-story ☐ Two-story ☐ Assisted living facility Facility name _____ ☐ Other _____
Durable medical equipment	☐ Yes ☐ No	Wheelchair _____ Oxygen _____ Walker _____ Nebulizer _____ Cane _____ CPAP/BIPAP _____ Other _____
Can you afford medicines?	☐ Yes ☐ No	If no, there may be patient assistance programs available.
Transportation provided by?		

Nutritional history:

Current weight: _____ lbs.	Current height: _____ ft. _____ in. Weight changes in the past 6 months? ☐ Yes ☐ No

Current diet plan:

Exercise/activity:

Current activity:	How often:

Physical limitations: _____

Activities of daily living:

Do you require assistance to bathe or groom?	☐ Yes ☐ No	If yes, explain: _____ _____ _____
Do you require assistance for your toilet needs?	☐ Yes ☐ No	If yes, explain: _____ _____ _____
Do you require assistance to eat?	☐ Yes ☐ No	If yes, explain: _____ _____ _____
Do you have hearing loss?	☐ Yes ☐ No	Do you wear hearing aids? ☐ Yes ☐ No Last hearing exam date: _____

Additional comments and notes: _____

_____

Preventive service history

_____ _____ _____ _____ / _____ / _____

Patient last name | First name | MI | Date of birth

Preventive services	Date received	Findings and recommendations
Bone Mass Measurement (Density)		
Cardiovascular disease screening		☐ Hypercholesterolemia
Cholesterol	_____	☐ Hyperlipidemia
LDL	_____	☐ Other: _____
EKG	_____	EKG results: _____
Colorectal cancer screening		
Flexible sigmoidoscopy	_____	
Barium enema	_____	
Colonoscopy (not high risk)	_____	
Fecal occult blood test	_____	
Diabetes screening		
HgA1c	_____	☐ Cataracts
Foot exam	_____	☐ Other: _____
Eye exam	_____	
Glaucoma screening		☐ Glaucoma
PAP and pelvic examination		
Prostate cancer screening Digital Rectal Exam (DRE) Prostate Specific Antigen Test (PSA)		
Mammogram screening Breast self exam Mammogram		

Declaration to decline life-prolonging procedure (Living Will)

__ I have made such a declaration.

__ I have NOT made such a declaration.

Health Care Surrogate (The person you choose to make health care decisions for you if you can't speak for yourself.)

__ I have chosen a Health Care Surrogate.

__ I have NOT chosen a Health Care Surrogate.

Durable Power of Attorney (A legal document that names a person who can make decisions if you are unable to.)

__ I have appointed a Durable Power of Attorney for health care decisions.

__ I have NOT appointed a Durable Power of Attorney for health care decisions.

Patient's printed name _____ Signature _____ Date _____ / _____ / _____

Date reviewed: _____ Provider signature: _____