



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

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

_____-_____-_____
Home # Cell Phone #

Home Address City State Zip

SS# _____-_____-_____
 Single Married Divorced Widowed

Employer _____
Race: American Indian/Alaska Native Asian Black White Hispanic
 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 said 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) _____

Patient medical history

_____/_____/_____
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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 Female Gender Neutral
 (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)

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	<input type="checkbox"/>	<input type="checkbox"/>	CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol overuse	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Ostomies _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (other than medications)	<input type="checkbox"/>	<input type="checkbox"/>	Falls	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Cancer location: _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/MI	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	Other heart disease (CHF/CAD)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker: _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>			
			Measles/Mumps	<input type="checkbox"/>	<input type="checkbox"/>			

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 _____ If no, when did you quit? _____
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

_____/_____/_____
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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	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		Yes	No	Relationship to you
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Intestinal polyps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital				Nervous breakdown	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	_____	Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____				

_____/_____/_____
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Medications:

<input type="checkbox"/> Asthma Wheezing Medicine	<input type="checkbox"/> Sleeping Pills/Tranquilizers
<input type="checkbox"/> Aspirin, Bufferin, Anacin, Tylenol or Similar Products	<input type="checkbox"/> Thyroid Medicine
<input type="checkbox"/> Blood Pressure Pills	<input type="checkbox"/> Stomach/Digestive Medicine
<input type="checkbox"/> Cortisone, Prednisone	<input type="checkbox"/> Weight-Reducing Pills
<input type="checkbox"/> Cough Medicine	<input type="checkbox"/> Blood Thinners or Coumadin
<input type="checkbox"/> Digitalis or Heart Medicine	<input type="checkbox"/> Dilantin or Seizure Medications
<input type="checkbox"/> Hormones	<input type="checkbox"/> Water Pills or Diuretics
<input type="checkbox"/> Insulin or Diabetic Pills	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Anemia Medications	<input type="checkbox"/> Phenobarbital/Barbiturates
<input type="checkbox"/> Laxatives	<input type="checkbox"/> Vitamins
	<input type="checkbox"/> Other Prescription or Over-the-Counter Drugs

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

_____/_____/_____
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Social / lifestyle history:

PrimaryLanguage:_____

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

Potential Referral to Patient Assistance Program

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

_____/_____/_____
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Preventive Services	Date Received	Findings and Recommendations
Bone Mass Measurement (Density) Cardiovascular Disease Screening Cholesterol LDL EKG	_____ _____ _____	<input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Other: _____ EKG Results: _____
Colorectal Cancer Screening Flexible Sigmoidoscopy Barium Enema Colonoscopy (not high risk) Fecal Occult Blood Test	_____ _____ _____ _____	
Diabetes Screening HgA1c Foot Exam Eye Exam	_____ _____ _____	<input type="checkbox"/> Cataracts <input type="checkbox"/> Other: _____
Glaucoma screening		<input type="checkbox"/> 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

- I have designated a Health Care Surrogate
 I have NOT designated a Health Care Surrogate

Durable Power of Attorney

- 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: _____