JASSER CENTER
FOR COMPREHENSIVE CARE

Patient Name: _____ Date of Birth:_____

Mailing Address: _____City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Social Security #:_____ Gender: _____ E-mail: _____

Pharmacy Name: _____ Pharmacy Address: _____

Marital Status:	Race:	Ethnicity:	Language:
☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated	☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ American Indian ☐ Other ☐ Refused	☐ Hispanic ☐ Not Hispanic ☐ Refused	☐ English ☐ Spanish ☐ Vietnamese ☐ Mandarin Chinese ☐ Hungarian ☐ Other

Are you currently employed? Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disabled ☐

Employer: _____Phone#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

**Do you have insurance through YOUR employer? Yes ☐ No ☐

Primary Insurance: _____

Policyholder Name: _____ Relationship to patient: _____

Policyholder date of birth: _____ Policyholder's Employer:_____

Policy/ID #: _____ Group #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____

Policyholder Name: _____ Relationship to patient: _____

Policyholder date of birth: _____ Employer: _____

Policy/ID #: _____ Group #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

****Do you have AHCCCS or Tertiary (3rd) Insurance**? ☐Yes ☐No

If yes, Plan Name/ID#: _____

Patient/Parent/Guardian Signature:

_____**Date:**_____

Name: _____ DOB: _____

What are the **most important** issue you want to discuss at today's office visit?

1. _____
2. _____

MEDICATIONS	Dose	Frequency	Reason taking

PAST OR PRESENT MEDICAL CONDITIONS - CHECK ALL THAT APPLY

- ☐ Hypertension
- ☐ Type 2 or 1 diabetes
  - Diabetes Complications:
  - ☐ Kidney (nephropathy)
  - ☐ Nerve (neuropathy)
  - ☐ Eye (retinopathy)
- ☐ Hyperlipidemia
- ☐ Hypothyroidism
- ☐ Thyroid nodule / goiter
- ☐ Elevated blood sugar
- ☐ Osteopenia / Osteoporosis
- ☐ Menopause
- ☐ Coronary artery disease / heart attack
- ☐ Atrial fibrillation
- ☐ Carotid stenosis
- ☐ Blood vessel disease (PVD)
- ☐ COPD / Asthma
- ☐ Asbestos exposure
- ☐ DVT / Pulmonary embolism
- ☐ Obstructive sleep apnea
- ☐ Positive TB skin test (PPD)
- ☐ Restless leg syndrome
- ☐ Chronic kidney insufficiency
- ☐ Gastroesophageal reflux
- ☐ Barrett's esophagus
- ☐ Crohn's / Ulcerative Colitis
- ☐ Celiac sprue
- ☐ History of colon polyps
- ☐ Hepatitis B or C
- ☐ Irritable bowel disease
- ☐ Rheumatoid arthritis
- ☐ Degenerative arthritis
- ☐ Psoriasis
- ☐ Systemic lupus erythematous
- ☐ Gout
- ☐ Chronic pain
- ☐ Alzheimer's / dementia
- ☐ Epilepsy /seizure
- ☐ Stroke (CVA)
- ☐ Parkinson's disease
- ☐ Peripheral neuropathy
- ☐ Migraine or Headaches
- ☐ Kidney stones
- ☐ Large prostate (BPH)
- ☐ Anemia
- ☐ Anxiety / depression
- ☐ Allergies
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Low vitamin B12 or D
- ☐ Chickenpox
- ☐ Cancer: _____ _____
- ☐ Other: _____ _____ _____

Women only:

Number of Pregnancies _____ # of live births _____ # of Miscarriage/Abortion _____

Name: _____ DOB: _____

ALLERGIES TO MEDICATIONS OR FOOD

Medications / Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES – CHECK ALL THAT APPLY

- ☐ Appendectomy
- ☐ Gallbladder surgery
- ☐ Vasectomy
- ☐ Prostate Surgery
- ☐ Hysterectomy
- ☐ Ovary Removal
- ☐ Breast Surgery
- ☐ Breast Biopsy
- ☐ Heart Bypass/Stent
- ☐ Bariatric Surgery
- ☐ C-section
- ☐ Thyroid Surgery
- ☐ Back/Neck Surgery
- ☐ Cataract Removal
- ☐ Tonsillectomy
- ☐ Transplant (list): _____
- ☐ Hernia (list): _____ _____
- ☐ Joint Surgery (list): _____ _____
- ☐ Other Surgery (list): _____ _____ _____ _____ _____

FAMILY HEALTH HISTORY

	Major medical problems	Age of death	Cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Sibling (#_____)	_____	_____	_____
Children (#____)	_____	_____	_____

In addition to completing the above information, please check all that apply to family history:

- ☐ Cancer of Breast/Ovarian or Prostate
- ☐ Colon Cancer
- ☐ Diabetes or Hypertension
- ☐ Early Heart Attack (before age 55 for men and 65 for women)

SOCIAL

Occupation: _____ Marital Status: _____ Living Will? …….. YES NO

Name: _____ DOB: _____

Tobacco Use

- ☐ Never
- ☐ Former Use…. Year quit _____ # Years smoked _____ # Packs/day _____
- ☐ Current Use…. Age started _____ # Packs/day _____

Alcohol Use

Did you have a drink containing alcohol in the past year? …… YES NO

How often did you have a drink containing alcohol?

- ☐ Monthly or less
- ☐ 2 to 3 times a WEEK
- ☐ 2 to 4 times a MONTH
- ☐ 4 or more times a WEEK

How many alcoholic drinks did you have on a typical day?

☐ 1 – 2 ☐ 3 – 4 ☐ 5 – 6 ☐ 7 – 9 ☐ 10 or more

How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never
- ☐ Monthly
- ☐ Daily or almost daily
- ☐ Less than monthly
- ☐ Weekly

PREVENTATIVE AND WELLNESS

Colonoscopy (month/year) _____ Result: _____

Eye exam (month/year) _____ Result: _____

Men only: Prostate blood test (month/year) _____

Women only: Bone density (month/year) _____ Gynecologist name _____

Mammogram (month/year) _____ Result: _____

Pap smear (month/year) _____ Result: _____

IMMUNIZATIONS

Tetanus (year) _____ Pneumovax (year) _____ Prevnar (year) _____

Hepatitis A (year) _____ Hepatitis B (year) _____ Chickenpox (year) _____

Shingles (year) _____ Gardasil/HPV (year) _____ Flu (month/year) _____

Fall Risk

Mobility Status (circle): Walking Walking with Assistance Wheelchair

Have you fallen in the past year (circle)? …… YES NO

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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	_____

Name: _____ DOB: _____

SPECIALIST PHYSICIANS that you see regularly (please list all)

_____

_____

_____

Name of your previous PCP (including city/state): _____

SYSTEM REVIEW - indicate if you have had any of the below symptoms in last 2 months

Rate your pain on a scale (0 = no pain; 10 = debilitating pain) _____

Excessive thirst or urination?	YES	NO
Significant headaches, slurred speech?	YES	NO
Double or blurred vision?	YES	NO
Diminished hearing or hoarseness?	YES	NO
Cough, shortness of breath, or wheezing?	YES	NO
Chest pain/pressure; rapid or irregular heartbeat?	YES	NO
Awakening at night short of breath?	YES	NO
Abnormal swelling in the legs or feet?	YES	NO
Pain or stiffness in your joints?	YES	NO
Abnormal nipple discharge or breast lump?	YES	NO
Skin rash, sore, or change of a mole?	YES	NO
Difficulty swallowing, heartburn, nausea, or vomiting?	YES	NO
Significant constipation or diarrhea; bloody or black bowel movements?	YES	NO
Do you feel you are at risk for sexually transmitted disease?	YES	NO
Weight loss of 10 pounds or more during the last 6 months?	YES	NO
Disruptive snoring?	YES	NO
Have others witnessed you stop breathing while sleeping?	YES	NO
Involuntary leakage of urinary?	YES	NO
Desire for hearing test?	YES	NO