

NEW PATIENT INTAKE FORM

Please complete this form, sign and return it to the receptionist. Thank you.

(Por favor complete y firme la forma. Gracias)

Date (Fecha): _____

PATIENT INFORMATION

Last Name (Apellido): _____

First Name (Nombre): _____

Address (Dirección): _____

City/State/Zip (Ciudad, Estado, Zona Postal): _____

Telephone Number (Teléfono): _____

Email (Correo Electrónico): _____

DOB (Fecha de Nacimiento): _____

Social security #: (Número de Seguro Social): _____

Male (Hombre): ☐

Female (Mujer): ☐

Single (Soltero/a): ☐

Married (Casado/a): ☐

Divorced (Divorciado): ☐

Employer (Empleador): _____

Employer Phone number (Empleador Teléfono): _____

☐

Retired

☐

Unemployed

☐

LOA

☐

Disabled

Emergency Contact - in case of emergency, who should we contact?

(En caso de una emergencia, a quién debemos de llamar?)

Name (Nombre): _____

Relationship to patient (Relación con el paciente): _____

Phone number (Número de la Casa): _____

Responsible Party (Persona Responsable)

Name (Nombre): _____

Relationship to patient (Relación con el paciente): _____

Birthdate (Fecha de Nacimiento): _____

Driver's License Number (Número de Licencia): _____

Thank you! / Gracias!

Patient Name: _____ Date of Birth: _____

CONSENT FOR VERBAL RELEASE OF INFORMATION

PLEASE LIST YOUR PREFERRED NUMBER	TYPE (PLEASE CIRCLE)	LEAVE DETAILED MESSAGE
Primary Phone Number:	Home ☐ Work ☐ Cell ☐ ☐ ☐ ☐	☐ Yes ☐ No
Secondary Phone Number:	Home ☐ Work ☐ Cell ☐ ☐ ☐ ☐	☐ Yes ☐ No

Name(s) of a person(s) that I authorize the disclosure of my health/financial information:

NAME	RELATIONSHIP	PHONE NUMBER	RELEASE TYPE
			☐ HEALTH ☐ FINANCE
			☐ HEALTH ☐ FINANCE
			☐ HEALTH ☐ FINANCE

AUTHORIZATION FOR TREATMENT OF A MINOR BY DELEGATED PERSONS

I hereby authorize that the following persons have my permission to seek medical treatment (*) of the above-named minor child in my absence and that his/her protected health information (**) may be shared.

Name: _____ Relationship to Patient: _____ Phone Number: _____

☐ SHORT-TERM AUTHORIZATION ☐ LONG-TERM AUTHORIZATION
 (30 days - held at reception desk) (In effect until revoked in writing)

* Medical treatment includes physical exams, routine radiology, laboratory tests, and immunizations.
 ** Protected health information includes but is not limited to test results, diagnosis, treatment, and billing information. Highly confidential information will not be released unless the parent/legal guardian has also completed an Authorization for Release of Confidential Health Information form. This information includes mental illness or developmental disability, psychotherapy notes, HIV or AIDS testing or treatment (including information regarding test ordering, performance, or results, regardless if the results were positive or negative), sexually transmitted disease, substance abuse, abuse of an adult with a disability, sexual assault, child abuse or neglect, genetic test.

Patient / Authorized Person (Please print): _____

Patient / Authorized Person Signature: _____ Date: _____

Relationship to Patient: _____



Medication list / Allergies

List your current medications, including vitamins, supplements, inhalers and herbal products.

[illegible]

ALLERGIES

Name the Drug	Reaction You Had

PHARMACY AND PRESCRIPTION INFORMATION

Primary Pharmacy: _____ Pharmacy Address (or Cross Streets): _____ City: _____

Pharmacy Phone #: _____

Ishminder Singh, M.D.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used for the:

- Treatment of me by multiple healthcare providers who may be involved,
- Reimbursement by my insurance company for any treatment received, and
- Normal healthcare operations, i.e., audit reviews, physician certifications.

I understand that I have the right to request restrictions on how you use and disclose my protected health information for the purpose of treatment, payment, or healthcare operations, that you are not required by law to grant my request(s), and that if you decide to grant my request for restrictions that you are then bound by the restrictions.

I know that I may revoke this acknowledgment in writing except to the extent that you have already used or disclosed my protected health information in reliance on my consent.

I understand and acknowledge that I have a legal right to review the notice of privacy practices before I sign this consent and I acknowledge that I have received a copy of this document.

By signing this form, you are granting consent to Elite Primary Physicians to use and disclose your protected health information for the purpose of treatment, payment, and health care operations.

Patient signature: _____

Date: _____

Print Patient Name: _____

YOUR RIGHTS AND RESPONSIBILITIES

As one of our patients, you have choices, rights, and responsibilities. You've made the choice to allow Ishminder Singh, M.D. of Elite Primary Physicians, Inc. to provide your care. We ask you to read and understand your rights and responsibilities listed below. Should any problems arise during the course of your care, please let us know and we will be more than happy to discuss them with you.

YOU HAVE THE RIGHT TO...

- 1. Be treated with dignity and respect.
- 2. Maintain your privacy and confidentiality.
- 3. Receive explanations about any tests or clinic procedures and any questions you may have.
- 4. Receive education and counseling.
- 5. Review your medical records with a doctor or practitioner.
- 6. Consent to or refuse any care or treatment.
- 7. Ask questions.

YOU ALSO HAVE THE RESPONSIBILITY TO...

- 1. Be honest about your medical history and lifestyle which may affect you.
- 2. Be sure you understand what you hear.
- 3. Follow health advice and instructions.
- 4. Respect the policies of the clinic/office.
- 5. Report any changes in your health.
- 6. Keep appointments or cancel them at least 24 hours in advance.
- 7. Respect office staff, physicians, and other patients.
- 8. Maintain a low noise level while in the doctor's office.
- 9. Maintain control of any child that comes with you on your office visit. We realize that you may sometimes have difficulty finding a baby-sitter, however, it makes our job difficult when we are distracted from providing the appropriate care to you. DO NOT ASSUME that the office staff will "watch" your children while you are visiting the doctor. Our staff members are quite busy and cannot watch your children.

Patient's Signature of Acknowledgement _____

Date _____

ELITE PRIMARY PHYSICIANS, INC.

WELLNESS VISIT ACKNOWLEDGMENT & FINANCIAL POLICY

Patient Name: _____

DOB: _____

Date: _____

Purpose of Today's Visit

Today's appointment is scheduled as a preventive/wellness visit.

This type of visit focuses on:

- Routine physical examination
- Preventive screening and counseling
- Health maintenance
- Review of age-appropriate labs, vaccines, and risk factors

Important Billing Information

A wellness visit does not include evaluation or management of new or ongoing medical problems.

If additional medical concerns are addressed during today's visit, your provider may need to bill for both a preventive visit and a problem-oriented visit. This may result in additional charges, including copays, coinsurance, or deductible costs, depending on your insurance plan.

Examples of Concerns That May Result in Additional Billing

- New symptoms (e.g., chest pain, abdominal pain, headaches, fatigue)
- Chronic condition management (e.g., diabetes, hypertension, high cholesterol)
- Medication adjustments or refills requiring medical decision-making
- Mental health concerns (e.g., anxiety, depression, insomnia)
- Review of abnormal labs or imaging
- Acute illnesses (e.g., infections, rashes, injuries)
- Procedures (e.g., joint injections, skin procedures, EKG interpretation)

Your Options

- Your provider may address them during today's visit if time permits, and bill accordingly
- You may choose to schedule a separate appointment to avoid additional charges today
- You may decline to address the concern at this time

Patient Acknowledgment

I understand that:

- My insurance may cover preventive visits at 100%, but problem-based visits may require cost-sharing
- If additional medical concerns are addressed, I may receive separate charges
- Coverage and out-of-pocket costs are determined by my insurance plan
- I have the right to ask about potential costs before additional services are provided

Patient Signature: _____

Date: _____

ELITE PRIMARY PHYSICIANS, INC.

200 N Harbor Blvd. Suite 100, Anaheim,

CA 92805 Phone: 714-533-7021

Teaching and Training Participation Consent Form

Purpose:

At Elite Primary Physicians, we also teach to train future healthcare professionals.

Our mission is to provide high-quality, compassionate care while supporting the education and professional development of the next generation of clinicians.

- Obtain your medical history
- Perform parts of a physical examination

Explanation:

As part of your visit today, you may be seen by a medical student, physician assistant (PA) student, nurse practitioner (NP) student, or resident physician/medical student under the supervision of your attending provider.

- Discuss your care plan with the supervising provider

All findings and care decisions are reviewed and approved by your supervising physician or provider before final recommendations are made.

Your Rights:

- Your participation in this teaching environment is completely voluntary.
- You may decline to have a student involved in your care at any time.
- Refusal will not affect your treatment or your relationship with our clinic.

Consent

I acknowledge that I have read and understood the above information. I understand that Elite Primary Physicians also serves as a training site for future healthcare professionals and that students may participate in my care under supervision. I consent to the involvement of students during my visit.

Patient Signature: _____

Date: _____

ELITE PRIMARY PHYSICIANS, INC.

MEDICATION REFILL POLICY

- 1. Patients should request refills at least 3-5 business days before medications are due.
- 2. Refill requests should be submitted during regular business hours.
- 3. Certain medications may require follow-up appointments, laboratory monitoring, or additional evaluation prior to refill authorization.
- 4. Controlled substance refill requests are subject to additional review and may require in-person evaluation.
- 5. Early refill requests are not guaranteed.
- 6. Refill requests submitted after hours, on weekends, or holidays may not be processed until the next business day.
- 7. Patients are responsible for keeping scheduled follow-up appointments necessary for ongoing medication management.
- 8. Medications prescribed by outside specialists may need to be managed by the prescribing specialist.
- 9. Repeated missed appointments or noncompliance may affect refill authorization.
- 10. The practice reserves the right to deny refill requests that are not clinically appropriate.
- 11. Emergency refill requests will be handled at provider discretion.
- 12. Patients should maintain an updated preferred pharmacy on file.

Patient Signature: _____

Date: _____

ELITE PRIMARY PHYSICIANS, INC.

TELEHEALTH INFORMED CONSENT

- 1. Telehealth services may include medical evaluation, treatment recommendations, medication management, follow-up care, and review of diagnostic studies.
- 2. Telehealth has limitations and may not replace in-person medical evaluation when clinically necessary.
- 3. Technical failures, interruptions, or privacy risks may occasionally occur despite reasonable safeguards.
- 4. I may be asked to attend an in-person visit if clinically appropriate.
- 5. In emergencies, I should call 911 or seek emergency medical care.
- 6. Prescribing decisions remain subject to clinical judgment and legal requirements.
- 7. My medical information will be protected in accordance with HIPAA and applicable privacy laws.
- 8. I may withdraw consent for telehealth services at any time.
- 9. I consent to receive healthcare services via telehealth from Elite Primary Physicians, Inc.

Patient Name: _____

DOB: _____

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____

ELITE PRIMARY PHYSICIANS, INC.

CONTROLLED SUBSTANCE AGREEMENT

- 1. Controlled medications are prescribed only when medically appropriate.
- 2. Patients may be required to attend regular follow-up appointments.
- 3. Early refills are not guaranteed.
- 4. Lost, stolen, or damaged medications may not be replaced.
- 5. The practice may require in-person evaluation before refills.
- 6. Urine drug screening, pill counts, specialist consultation, or additional monitoring may be required.
- 7. Patients should use one pharmacy whenever possible.
- 8. Controlled medications should only be taken as prescribed.
- 9. Sharing or selling medications is prohibited.
- 10. Multiple missed appointments or repeated noncompliance may result in discontinuation of controlled medication prescribing.
- 11. Aggressive, threatening, abusive, or inappropriate behavior toward staff may result in termination from the practice.
- 12. The practice reserves the right to modify treatment plans based on clinical judgment and applicable laws.
- 13. CURES may be reviewed in accordance with California law.

Patient Name: _____

DOB: _____

Patient Signature: _____

Date: _____

ADVANCED DIRECTIVES ACKNOWLEDGEMENT FORM

Member Name: _____ Date: _____

- ☐ I do have an Advanced Directive/Living Will/Durable Power of Attorney for medical or health care decisions.
- ☐ I do not have an Advanced Directive/Living Will/Durable Power of Attorney for medical or health care decisions.
- ☐ I would like further information on Advanced Directives.
- ☐ I would not like further information on Advanced Directives.

Member's Signature: _____

Date: Physician or Office Staff please complete:

- ☐ Information regarding Advanced Directive was provided.
- ☐ Information regarding Advanced Directive was not provided.

If information was provided, what type? ☐ Verbal ☐ Written

If the member has an Advanced Directive, has it been placed in the Medical Record: ☐ Yes ☐ No

Comments:

Physician or Staff Signature: _____ **Date:** _____

Housing

- Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?¹
☐ Yes
☐ No
- Think about the place you live. Do you have problems with any of the following? (check all that apply)²
☐ Bug infestation
☐ Mold
☐ Lead paint or pipes
☐ Inadequate heat
☐ Oven or stove not working
☐ No or not working smoke detectors
☐ Water leaks
☐ None of the above

Food

- Within the past 12 months, you worried that your food would run out before you got money to buy more.³
☐ Often true
☐ Sometimes true
☐ Never true
- Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.³
☐ Often true
☐ Sometimes true
☐ Never true

Transportation

- Do you put off or neglect going to the doctor because of distance or transportation?¹
☐ Yes
☐ No

Utilities

- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?⁴
☐ Yes
☐ No
☐ Already shut off

Child care

- Do problems getting child care make it difficult for you to work or study?⁵
☐ Yes
☐ No

Employment

- Do you have a job?⁶
☐ Yes
☐ No

Education

- Do you have a high school degree?⁶
☐ Yes
☐ No

Finances

- How often does this describe you? I don't have enough money to pay my bills:⁷
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

Personal safety

- How often does anyone, including family, physically hurt you?⁸
☐ Never (1)
☐ Rarely (2)
☐ Sometimes (3)
☐ Fairly often (4)
☐ Frequently (5)
- How often does anyone, including family, insult or talk down to you?⁸
☐ Never (1)
☐ Rarely (2)
☐ Sometimes (3)
☐ Fairly often (4)
☐ Frequently (5)

13. How often does anyone, including family, threaten you with harm?⁸

- ☐ Never (1)
☐ Rarely (2)
☐ Sometimes (3)
☐ Fairly often (4)
☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?⁸

- ☐ Never (1)
☐ Rarely (2)
☐ Sometimes (3)
☐ Fairly often (4)
☐ Frequently (5)

Assistance

15. Would you like help with any of these needs?

- ☐ Yes
☐ No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: _____

Greater than 10 equals positive screen for personal safety.

References

1. https://www.va.gov/HOMELESS/Universal_Screener_to_Identify_Veterans_Experiencing_Housing_Instability_2014.pdf
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3. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics*. 2010;126(1):e26-e32.
4. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics*. 2008;122(4):e867-e875.
5. Children's HealthWatch. Final: 2013 Children's Healthwatch survey. <http://www.childrenshealthwatch.org/methods/our-survey/>. Accessed October 3, 2018.
6. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE project. *Pediatrics*. 2007;120(3):547-558.
7. Aldana SG, Liljenquist W. Validity and reliability of a financial strain survey. *J Financ Couns Plan*. 1998;9(2):11-19.
8. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med*. 1998;30(7):508-512.

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Advancing health equity in every community



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Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee



Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
6. Did you live with anyone who went to jail or prison?	☐
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
9. Did you feel that no one in your family loved you or thought you were special?	☐
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health?

☐ Not Much ☐ Some ☒ A Lot

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

Abuse Assessment Screen

Instructions: Circle Yes or No for each question

1. Have you ever been emotionally or physically abused by your partner or someone important to you? ☐ YES ☐ NO

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ☐ YES ☐ NO

If YES, who? (Circle all that apply)

☐ Husband ☐ Ex-Husband ☐ Boyfriend ☐ Stranger ☐ Other ☐ Multiple

Total no. of times _____

3. Since you've been pregnant, have you been slapped, kicked or otherwise physically hurt by someone? ☐ YES ☐ NO

If YES, who? (Circle all that apply)

☐ Husband ☐ Ex-Husband ☐ Boyfriend ☐ Stranger ☐ Other ☐ Multiple

Total no. of times _____

Mark the area of injury on the body map. Score each incident according to the following scale:

SCORE

1 = Threats of abuse including use of weapon _____

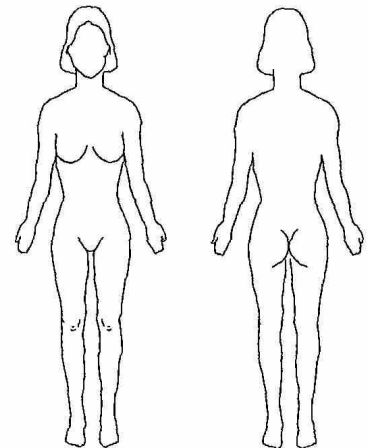
2 = Slapping, pushing; no injuries and/or lasting pain _____

3 = Punching, kicking, bruises, cuts, and/or continuing pain _____

4 = Beating up, severe contusions, burns, broken bones _____

5 = Head injury, internal injury, permanent injury _____

6 = Use of weapon; wound from weapon _____



4. Within the last year, has anyone forced you to have sexual activities? ☐ YES ☐ NO

If YES, who? (Circle all that apply)

☐ Husband ☐ Ex-Husband ☐ Boyfriend ☐ Strange ☐ Other

Multiple Total no. of times _____

5. Are you afraid of your partner or anyone you listed above? ☐ YES ☐ NO

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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 and 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 have let yourself or your family down newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

OR OFFICE CODING + + +
=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
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
<i>Add the score for each column</i>		+	+	+
Total Score (<i>add your column scores</i>) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.



TUBERCULOSIS SCREENING

Is the patient or has the patient had:

YES

NO

1. Infected with HIV?

☐
☐

2. Close contact of persons with known or suspected TB (including health care workers)?

☐
☐

3. Medical risk factors associated with TB?

☐
☐

4. An immigrant from a country with high TB prevalence (e.g. most countries in Africa, Asia, and Latin America)?

☐
☐

5. Of the medically-underserved low-income (including high-risk racial or ethnic minority populations)?

☐
☐

6. An alcoholic?

☐
☐

7. An injection drug user?

☐
☐

8. A resident of long-term care facilities (e.g. correctional institutions, mental institutions, nursing homes)?

☐
☐

HEPATITIS RISK ASSESSMENT

Check your risk of hepatitis A, B, and C.

CHECK YOUR RISK OF HEPATITIS A

QUESTION	YES	NO
1. Do you believe you have been exposed to hepatitis A in the past 2 weeks?	☐	☐
2. Do you live with someone currently ill with hepatitis A?	☐	☐
3. Have you had sex with someone currently ill with hepatitis A?	☐	☐
4. Do you currently live in a region of the United States where hepatitis A rates are very high?	☐	☐
5. Do you travel to or work in an area outside of the United States where hepatitis A is a problem? (This includes everywhere EXCEPT Australia, New Zealand, Western Europe, Japan, and Canada)	☐	☐
6. If you are a man, do you have sex with other men?	☐	☐
7. Are you an injecting or a non-injecting (snort cocaine) drug user?	☐	☐

If you check yes to any of the questions you are at risk and should see your doctor.

CHECK YOUR RISK OF HEPATITIS B

QUESTION	YES	NO
1. Is someone in your household infected with hepatitis B?	☐	☐
2. Have you ever been diagnosed with a sexually transmitted disease?	☐	☐
3. Have you had sex with more than one partner in a 6-month period?	☐	☐
4. If you are a man, do you have sex with other men?	☐	☐
5. Have you or any of your sex partner(s) ever injected illegal drugs?	☐	☐
6. Have you ever shared equipment (needles, syringes, cotton, water, etc) when injecting drugs with someone else?	☐	☐
7. Have you ever received hemodialysis?	☐	☐
8. Did your mother have hepatitis B when you were born?	☐	☐
9. Have you worked in a health care or other occupation where you had a needlestick injury or other sharps exposures on the job?	☐	☐
10. Have you shared a toothbrush, razor, or any other item that might have blood on it (visible or not) with a person who has hepatitis B?	☐	☐

If you check yes to any of the questions you are at risk and should see your doctor.

CHECK YOUR RISK FOR HEPATITIS C

QUESTION	YES	NO
1. Did you receive a blood transfusion or solid organ transplant (heart, lung, liver, pancreas, kidney) before July 1992?	☐	☐
2. Did you receive clotting factor concentrates produced before 1987?	☐	☐
3. Have you ever received hemodialysis?	☐	☐
4. Have you had blood tests that showed a liver problem?	☐	☐
5. Have you had a needlestick injury working in a health care setting?	☐	☐
6. Did your mother have hepatitis C when you were born?	☐	☐
7. Have you shared a toothbrush, razor, or any other item that might have blood on it (visible or not) with a person who has hepatitis C?	☐	☐
8. Have you or any of your sex partner(s) injected illegal drugs, even if it was only one time many years ago?	☐	☐

If you check yes to any of the questions you are at risk and should see your doctor.

Adapted from the Immunization Action Coalition (IAC) - <https://www.health.ny.gov/diseases/communicable/hepatitis/assessment.htm>

AUDIT-C Alcohol Use Questionnaire

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking. The following questions are about your drinking habits.

To help you answer correctly, we've listed the serving size of one drink below the questions.

Circle your answers. Then find your score in the top row above your answer. At the end, total your scores and look at the back of this sheet to rate your drinking habits.

Questions	0	1	2	3	4	Your score
1. How often did you have one drink containing alcohol in the last year?	I don't drink alcohol	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
3. How often did you have six or more drinks on one occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

Standard serving of one drink:



12 ounces of beer or malt beverage

1.5 ounces of 80 proof liquor

5 ounces of wine

4 ounces of sherry, liqueur, or aperitif

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name:

Which recreational drugs have you used in the past year? (Check all that apply)

- ☐ methamphetamines (speed, crystal) ☐ cocaine
☐ cannabis (marijuana, pot) ☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ inhalants (paint thinner, aerosol, glue) ☐ hallucinogens (LSD, mushrooms)
☐ tranquilizers (valium) ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	☐ No	☐ Yes
2. Do you abuse (use) more than one drug at a time?	☐ No	☐ Yes
3. Are you unable to stop using drugs when you want to?	☐ No	☐ Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	☐ No	☐ Yes
5. Do you ever feel bad or guilty about your drug use?	☐ No	☐ Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	☐ No	☐ Yes
7. Have you neglected your family because of your use of drugs?	☐ No	☐ Yes
8. Have you engaged in illegal activities in order to obtain drugs?	☐ No	☐ Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ No	☐ Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	☐ No	☐ Yes

0 1

Do you inject drugs? No ☐ Yes ☐

Have you ever been in treatment for a drug problem? No ☐ Yes ☐

I II III IV
0 1-2 3-5 6

