Dear____,

Thank you for choosing to participate in the Shared Medical Visits and improve your health through lifestyle change! By choosing to participate you will have the opportunity to:

- Become a member of a small group of patients with concerns just like yourself.
- Help create an environment of shared learning that supports others in the group.

Most of the time when you come in to the clinic, you are ill or having specific problems that we need to talk about. Discussions about managing or improving your health are often hard to fit into these short visits. The purpose of this group is improved health. In the group we will discuss ways you can maintain or improve your health and make sure you are up-to-date with care recommended for you.

There are some commitments that will need to be made in order for us to ensure you are receiving the best care possible:

¬ At times there will be forms that will need to be filled out and returned prior to the actual visit date. We will need to have these forms filled out to the best of your ability and returned to us at least three days prior to your visit. This will allow us to provide you with the best possible individual care and make sure you are getting the most from your visits.

¬ There may be times when you will be asked to have certain labs drawn. These labs will need to be drawn five days prior to your next Shared Medical Visit. This allows time for the results to be sent to our office and your provider to review them before your visit. You will be given a lab slip if labs are needed.

¬ No Show/Cancellation Policy: In the event that you need to cancel your appointment, we ask for a minimum of 24 hours notice. If we do not receive notification and you do not show up for you appointment we will consider this a “no-show.” We will apply a $50.00 charge to your account for all missed appointments for which you do not provide proper notification for. This policy allows us to accommodate other patients in need of appointments when we are given proper notification.

We ask that you please SIGN this form recognizing your commitment to the Shared Medical Visits and improving your health, and return this form with included history forms as indicated above (3 days prior to your visit).

Please return this packet to:
Shared Medical Visits
ATTN: Meri
3144 State Street
Medford, OR 97504

Or fax them to: 494-1050
Attn: Meri

Patient Signature____Date_______________________

Updated 10/07 MS   Please call Meri with any questions or concerns at 494-1050

SHARED MEDICAL VISIT HEALTH QUESTIONNAIRE

Patient Name____DOB_________________________

To better assist your individual needs for future treatment and testing during your Shared Medical Visit (SMV) we ask that you complete this form. The data provided may be shared with others participating in your SMV unless otherwise specified.

______ Keep SMV health questionnaire information separate from group discussion

_______I have a private question

Please list your two most critical concerns

#1____
#2____

Please give a history for concern #1

When did this first become a problem?____

Lately this has been: (Circle: Better Worse Unchanged)

How often does this affect your life? ____

Some Foods make this (Circle: Better Worse Unchanged)

Which foods make it worse? ____

Some medicines make this: (Circle: Better Worse Unchanged)

Which medicines help?____

On a scale of 1 – 10, please rate how this symptom impacts your life ___________________________

Please give a history for concern #2

When did this first become a problem?____

Lately this has been: (Circle: Better Worse Unchanged)

How often does this affect your life? ____

Some Foods make this (Circle: Better Worse Unchanged)

Which foods make it worse? ____

Some medicines make this: (Circle: Better Worse Unchanged)

Which medicines help?____

On a scale of 1 – 10, please rate how this symptom impacts your life ____________________________

Patient Signature____________________________________**Date**_________________

NAME ______________________________

REVIEW OF SYMPTOMS (check all you have had in the last month)

EYES, EARS, NOSE, THROAT
- [ ] Eye/Vision(Blurred,halso,double,flashes)
- [ ] Wear glasses/contacts
- [ ] Ear/hearing problems/ringing
- [ ] Sinus problems
- [ ] Voice hoarse
- [ ] Problem w teeth & gums
- [ ] Trouble Swallowing
- [ ] Nasal D/C, congestion
- [ ] Nose bleeds
- [ ] Bleeding Gums

RESPIRATORY
- [ ] Wheezing, gasp to breathe
- [ ] Chronic cough
- [ ] Persistant colds
- [ ] Unusual sweating

CARDIOVASCULAR
- [ ] High blood pressure
- [ ] Pain or tightness in chest
- [ ] Racing heart/palpitations
- [ ] Shortness of breath
- [ ] Swollen ankles/feet
- [ ] Varicose veins

DIGESTION
- [ ] Excessive hunger,thirst
- [ ] Pain in stomach
- [ ] Persistant nausea
- [ ] Rectal bleeding
- [ ] Heartbearn/indigestion
- [ ] Frequent diarrhea
- [ ] Chronic constipation
- [ ] Rapid change in weight
- [ ] Vomited blood
- [ ] Stools black or tarry

URINARY
- [ ] Frequent Urination at night
- [ ] Blood in urine
- [ ] Loss of urine (incontinence)
- [ ] Burning w/urination
- [ ] Excessive urination

MALE GENITAL
- [ ] Urine stream slow/weak
- [ ] Prostate problems
- [ ] Inability to ejaculate
- [ ] Inability to maintain erection
- [ ] Painful testicles
- [ ] Swelling of testicles/penis
- [ ] Cancer of testicles
- [ ] Burning/Discharge from penis

FEMALE GENITAL
- [ ] Heavy periods
- [ ] Painful cramps
- [ ] Irregular periods
- [ ] Bleeding between periods
- [ ] Vaginal discharge/itching
- [ ] Vaginal dryness
- [ ] Uterine/ovarian/cervical cancer
- [ ] Breast lumps
- [ ] Nipple discharge
- [ ] Cysts in breasts
- [ ] Breast cancer
- [ ] Abnormal PAP

MUSCULOSKELETAL
- [ ] Pain in muscles
- [ ] Stiff joints/swollen joints
- [ ] Osteoporosis
- [ ] Arthritis
- [ ] Weakness

NEUROLOGICAL/PSYCHOLOGICAL
- [ ] Depression
- [ ] Anxiety
- [ ] Convulsions/Seizures
- [ ] Trembling/Shakiness
- [ ] Numbness
- [ ] Headaches more than 1/week

CONSTITUTIONAL
- [ ] Weight change 10lbs or more in 6 mos
- [ ] recent loss of appetite
- [ ] Swelling in neck/armpits/groin
- [ ] Recent fevers
- [ ] Dizziness
- [ ] Fainting

HEALTH RISK FACTORS
- [ ] Diet to extreme
- [ ] Binge eat/vomit
- [ ] High sugar diet
- [ ] Skip meals
- [ ] Drink Alcohol
- [ ] #____/Day #___Years ___yr quit
- [ ] Smoke Cigarettes/Chew tobacco
- [ ] #____/Day #___Years ___yr quit
- [ ] Recreational Drugs
- [ ] Type_____________IV?_______
- [ ] Frequency__________________
- [ ] HIV test
- [ ] Wear seatbelts
- [ ] Wear bike/motorcycle helmets

CHANGES TO MEDICATIONS SINCE LAST VISIT:

____

____

NO MEDICATION CHANGES SINCE LAST VISIT ☐

CHANGES TO DIETARY SUPPLEMENTS SINCE LAST VISIT:

____

____

NO SUPPLEMENT CHANGES SINCE LAST VISIT ☐

CHANGES TO FAMILY HISTORY SINCE LAST VISIT

____

____

NO CHANGES TO FAMILY HISTORY SINCE LAST VISIT ☐

SIGNATURE **DATE**
____