HUNTERDON FAMILY PHYSICIANS

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Dear Patient,

Please arrive 15 minutes prior to the appointment with your current insurance card for check in. Make sure you have nothing to eat or drink 8 hours before your appointment, except you should drink plenty of water. Feel free to enjoy a cup of black coffee (no cream and/or sugar added).

In this packet, you will find some questionnaires and forms that we ask you to fill out and **bring with you to your appointment**. The information will be very important to your practitioner to provide you with the optimal care that you deserve. Be sure to complete both sides of each page.

If you need to cancel or reschedule your appointment, please give us 24 hours advance notice.

We look forward to assisting you in living a healthy life.

Sincerely,

Hunterdon Family Physicians

Patient Name: _____ Date of Birth: _____

<u>FAMILY HISTORY</u> - Since your last physical with us, are there any changes in your family history that you would like us to know? Please list in the space provided below.

_____

_____

<u>CHRONIC CONDITIONS</u> - Since your last physical with us, have you had any new conditions that you would like us to know? *Listed below are some examples of common diagnoses, please circle all that apply or write diagnoses in the space provided.*

ADD	Anxiety	Asthma	Congestive heart failure	COPD
Depression	Diabetes	GERD	High blood pressure	High cholesterol

_____

_____

Since your last physical with us, have you had any surgeries? If yes, please tell us about it below.

_____

_____

<u>SOCIAL HISTORY</u>

SMOKING - 1) Non-smoker

2) Current Smoker : How many packs per day? _____

3) Former Smoker : a) How long ago? ____ yrs b) Smoked for _____ yrs

4) Do you have asthma? YES NO

ALCOHOL - Do you drink alcohol? YES NO

If Yes, a) How often? _____ b) How much? _____

<u>SPECIALISTS</u> - Since your last physical with us, have you seen any specialists? Please provide us with their names and phone numbers. *Listed below are some commonly seen specialties, you may also enter additional ones in the space provided.*

	<u>Specialist's name</u>	<u>Phone number</u>
Allergy		
Cardiology		
Dermatology		
Ear/Nose/Throat (ENT)		
Endocrinology		
Gastroenterology		
Hematology / Oncology		
Neurology		
Ophthalmology / Optometrist		
Orthopedic		
Pulmonary		
Other		

_____

Do you have a health care proxy or surrogate decision maker? YES NO

If Yes, who? _____

Do you have an advance directive of living will? *Please circle an answer and follow the instruction.*

** **YES - your office already has copy.**

** **YES - I will bring a copy, so it can be scanned into my medical record.**

** **NO - please use the form on following page to establish one.**

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Tel (908) 284-9880; Fax (908) 782-4316

111 Hwy 31, Suite 111
Flemington, NJ 08822

☐ **I decline to fill out / provide this document.** Print name _____
Patient signature _____ Date _____ Date of Birth _____

Advance Directive (Living Will) - To My Family, Doctors, and All Those Concerned with My Medical Care:

I, _____, being of sound mind, make this statement as a directive to be followed if for any reason I become unable to participate in decisions regarding my medical care *(initial any and all that apply)*.

A. _____1. I direct that life-sustaining procedures be ***withheld*** or ***withdrawn:*** a) if I become permanently unconscious; b) if I have a terminal illness; c) if I experience extreme mental deterioration; or d) if I have another type of irreversible illness. The above conditions shall have no reasonable expectation of recovery or chance of regaining a meaningful quality of life. These medical conditions shall be determined by my attending physicians and at least one additional physician. I understand that I will be kept comfortable.
OR
_____2. I direct that all medically appropriate measures be provided to sustain my life, regardless of physical or mental condition.

B. This section asks you to think about the values that are important to you regarding treatment in case of severe mental or physical illness.
_____1. I do not wish my life to be prolonged by medical treatment(s) if my quality of life is unacceptable to me.
The following are conditions that are **unacceptable** to me. *(Initial only those that describe a way of living that you could not tolerate):*
_____a) Permanently unconscious with a ventilator breathing for me.
_____b) Permanently unconscious with a feeding tube and/or intravenous (IV) hydration.
_____c) On a ventilator when there is little or no chance of recovery.
_____d) Being conscious (awake), but unable to communicate (for example, with a stroke), and being fed with a feeding tube and/or hydrated with IV's to keep me alive.
_____e) Living with a dementia like Alzheimer's disease so severe that I am unable to recognize those who love me.
OR
_____2. I want to live as long as possible, regardless of the quality of life that I experience.

C. If chose A above, the life-sustaining procedures that would be withheld or withdrawn include but are not limited to: CPR, mechanical ventilation, surgery, chemotherapy, radiations, dialysis, transfusion, and antibiotics. *Initial the following if it applies to you.*

_____ In the circumstances described in A.1 above, I also direct that artificially provided nutrition and fluids be withheld and withdrawn and that I be allowed to die.

D. _____ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

Additional Comments or Exceptions:

_____

These directions express my legal right to request or refuse treatment. Therefore, I expect my family, doctor, and all those concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes.

Sign_____ **Date of Birth**_____ **Date**_____

Witnesses *(cannot be health care representatives or alternate representative if any are named on the other side of this page)*. I declare that the person who signed this document, or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness Sign_____ **Date** _____

Witness Sign_____ **Date** _____

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

Hunterdon Family Physicians

Secured Online Patient Portal

Our practice provides electronic communication with patients via NextMD Patient Portal.

Things you can achieve through the Patient Portal:

1. Email your physician with questions
2. Review your lab test results
3. Refill prescriptions
4. Request referrals

Follow these easy steps to sign up:

NAME: _____

DATE OF BIRTH: _____/_____/_____

EMAIL ADDRESS:_____

MOTHER'S MAIDEN NAME (for security): _____

CITY YOU WERE BORN IN (to retrieve password if you forget): _____

1. Create a user name with 7 or more letters (one or more must be a number)

   User Name _____

2. Create a password with 8 or more letters (one or more must be a number)

   Password _____

TEAR AND KEEP BELOW

User Name _____

Password _____

Login onto NEXT MD in your browser to sign into the Patient Portal. If at anytime you forget your username or password, it can always be reset. Call Lori (908) 284-9880.

FUNCTIONAL QUESTIONNAIRE

Are you able to do the following:

	Yes	No	Find it difficult to
ADL			
1. Dress yourself ……..	☐	☐	☐
2. Feed yourself …….……	☐	☐	☐
3. Toilet yourself ……..…….	☐	☐	☐
4. Groom yourself …….	☐	☐	☐
5. Physical ambulation ……..….	☐	☐	☐
IADL			
1. Handle your own finances …….	☐	☐	☐
2. Manage your medications …….	☐	☐	☐
3. Drive yourself around ……	☐	☐	☐
4. Get in and out of cars …….	☐	☐	☐
5. Walk ……	☐	☐	☐
6. Walk 5 to 10 blocks …….....	☐	☐	☐
7. Walk 10 blocks ……...	☐	☐	☐
8. Walk an unlimited distance …….	☐	☐	☐
9. Go up stairs …….	☐	☐	☐
10. Go down stairs …….	☐	☐	☐
11. Kneel down …….	☐	☐	☐
12. Exercise ……...	☐	☐	☐
13. Shop …….	☐	☐	☐
14. Food preparation ……..	☐	☐	☐
15. Housekeeping ……..	☐	☐	☐
16. Laundry ……	☐	☐	☐
17. Use telephone ……..	☐	☐	☐

Patient Name: _____ Date of Birth: _____

DEPRESSION QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than Half the days	Nearly everyday
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as Reading the newspaper or watching TV	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead, Or of hurting yourself in some way	☐	☐	☐	☐

10. If you checked off any problems above, 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

Patient Name: _____ Date of Birth: _____

HOME ENVIRONMENT / SAFETY

1. Do you have smoke detectors in home? YES NO
2. Do you have firearms in home? YES NO
3. Do you use seatbelt when in vehicle? YES NO
4. What type of heating system do you have at home? Gas Oil Electric _____
5. Do you have carbon monoxide detectors in home? YES NO
6. Do you have radon in home? YES NO If YES, is it treated? YES NO

FALL - Have you fallen in the past 12 months? YES NO

If Yes, did the fall result in an injury? YES NO

FOOD INSECURITY SCREENING

In the last 12 months, how do the following statements reflect your feeling?

1. I/We worried whether our food would run out before I/we got money to buy more.

   ☐ Often ☐ Sometimes ☐ Never

2. The food that I/we bought just didn't last and I/we didn't have money to get more.

   ☐ Often ☐ Sometimes ☐ Never