GREENVILLE HEALTH SYSTEM

Patient Information

(Please print)

Full Legal Name: ________________________________ Preferred Name: ____________
Last *First* *Middle*

Sex: ☐ Male ☐ Female

Date of Birth: ____________ SS#: ____________
Month/Day/Complete Year

Ethnicity: Hispanic/Latino ☐
Non-Hispanic/Non-Latino ☐
Refuse/Decline ☐

Primary Care Physician:________________________________

Preferred Pharmacy Name:________________________Phone Number:________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Legally Separated

Race: ☐ Caucasian (white) ☐ American Indian ☐ African American (black) ☐ Hispanic ☐ Biracial ☐ Asian Oriental ☐ Other ☐ Unknown

Home Address:________________________ City:____________ State: ________Zip: ________

Mail to Address: ________________________ City:____________ State: ________Zip: ________

County:____________ Home Phone: ( )________________ Cell Phone: ( )________________

Preferred language: ________________ E-mail: ________________________

Veteran: ___Yes ___No ___Unknown Religion: ________________________

Guarantor Information *(If guarantor is Self, skip to Emergency Contact)*
Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: ________________________________ Patient relation to Guarantor: ________________
Last *First* *Middle*

Home Phone: ( )________________

Date of Birth: ____________ SS#: ________________ Cell Phone: ( ) ________________

Home Address:________________________City: ____________ State:________Zip: ________ Country: ________

Mail to Address
(if different): ________________________City: ____________ State:________Zip: ________ Country: ________

Emergency Contact *(Pediatric Patients please list someone other than parent(s)/guardian)*

Primary Contact Name: ________________________________ Home Phone: ( ) ________________

Patient Relation to Emergency Contact ________________________________ Cell Phone: ( )________________

Secondary Contact Name: ________________________________ Home Phone: ( ) ________________

Patient Relation to Emergency Contact ________________________________ Cell Phone: ( )________________

Employment

Patient Employer: ________________________________ **Work Phone:**________________ **Ext:** ________

Address: ________________________________ **City:**____________ **State:** ________**Zip:**________

Employment Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time** ☐ **Student Part-Time** ☐ **Retired Date** ______ ☐ **Disabled** ☐ **Not Employed** ☐ **Unknown**

(Pediatric Patients Only) Parent/Guardian & Immediate Family Information

Mother *(If the address, phone numbers and employer information is the same as guarantor, please indicate same.)*

Full Name: ________________________________ Nickname: ________________
Last *First* *Middle*

Date of Birth: ________________
Month / Day / Complete Year

SS#: ________________

Home Address:________________________ City:____________ State: ________Zip: ________
(if different from patient)

Home Phone:________________________ Cell Phone: ( ) ________________

Employer:________________________ Work Phone: ( ) ________________ Ext:________

Father *(If the address, phone numbers and employer information is the same as guarantor, please indicate same.)*

Full Name: ________________________________ Nickname: ________________
Last *First* *Middle*

Date of Birth: ________________
Month / Day / Complete Year

SS#: ________________

Home Address:________________________ City:____________ State: ________Zip: ________
(if different from patient)

Home Phone:________________________ Cell Phone: ( ) ________________

Employer:________________________ Work Phone: ( ) ________________ Ext:________

Patient Name ______________________________ DOB ______________________________

(Pediatric Patients Only) Brothers, Sisters & Other Family Members

Full Name	*M or F*	*Date of Birth*	*Relationship*	*Lives with child*
				Yes No
				Yes No
				Yes No
				Yes No

☐ **Check here if no insurance. And, skip to Authorization (below).**

Accident Information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐ Yes ☐ No

Type of Accident: ____________ Date of Accident:____________ County of Accident: ____________

Primary Insurance Information

Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: ______________________________ Date of Birth: ____________
Month / Day / Complete Year

Patient Relationship to Subscriber: ____________ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: ______________________________ SS#: ____________

City, State, Zip: ______________________________ Home Phone:____________

Employer: ______________________________ Work Phone: ____________ Ext.________

Insurance Co. Name: ______________________________ **Phone:** ____________

Policy/Cert #:____________**Group No:** ____________ **Effective Date:**____________

Subscriber Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time**
☐ **Student Part-Time** ☐ **Retired Date** ________ ☐ **Disabled** ☐ **Not Employed**

Secondary Insurance Information

SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: ______________________________ Date of Birth: ____________
Month / Day / Complete Year

Patient Relationship to Subscriber: ____________ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: ______________________________ SS#: ____________

City, State, Zip: ______________________________ Home Phone:____________

Employer: ______________________________ Work Phone: ____________ Ext.________

Insurance Co. Name: ______________________________ **Phone:** ____________

Policy/Cert #:____________**Group No:** ____________ **Effective Date:**____________

Subscriber Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time**
☐ **Student Part-Time** ☐ **Retired Date** ________ ☐ **Disabled** ☐ **Not Employed**

Authorization

I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Health System for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: ______________________________ **Date:**____________

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 ________

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Sleep Disorder Screening Questionnaire

Patient Name______________________________________**Date**____________

- ☐ **1** **I have been told that I snore.**
- ☐ **2** **I have been told that I stop breathing when I sleep.**
- ☐ **3** **I have high blood pressure.**
- ☐ **4** **My friends and family say that I'm grumpy and irritable.**
- ☐ **5** **I have fallen asleep while driving.**
- ☐ **6** **I have noticed my heart pounding or beating irregularly during the night.**
- ☐ **7** **I get morning headaches.**
- ☐ **8** **I suddenly wake gasping for breath.**
- ☐ **9** **I am overweight**
- ☐ **10** **I seem to be losing my sex drive**
- ☐ **11** **I often feel sleepy and struggle to remain alert.**
- ☐ **12** **I frequently wake with a dry mouth.**
- ☐ **13** **I have difficulty falling asleep.**
- ☐ **14** **Thoughts race through my mind and prevent me from sleeping.**
- ☐ **15** **I anticipate a problem with sleep several times a week.**
- ☐ **16** **I wake up and cannot go back to sleep.**
- ☐ **17** **I worry about things and have trouble relaxing.**
- ☐ **18** **I wake up earlier in the morning than I would like to.**
- ☐ **19** **I lie awake for half an hour or more before I fall asleep.**
- ☐ **20** **When I am angry or surprised, I feel like my muscles go limp.**
- ☐ **21** **I often feel like I am in a daze.**
- ☐ **22** **I have experienced vivid dreamlike scenes.**
- ☐ **23** **I have fallen asleep in social settings such as the movies or at a party.**
- ☐ **24** **I have trouble at work because of sleepiness.**
- ☐ **25** **I have dreams soon after falling asleep or during naps.**
- ☐ **26** **I have "sleep attacks" during the day no matter how hard I try to stay awake.**
- ☐ **27** **I have had episodes of feeling paralyzed during my sleep or on awakening.**
- ☐ **28** **Other than when exercising, I still experience muscle tension in my legs.**
- ☐ **29** **I have noticed (or others have commented) that parts of my body jerk during sleep.**
- ☐ **30** **I have been told I kick at night.**
- ☐ **31** **When trying to go to sleep, I experience an Aching or crawling sensation in my legs.**
- ☐ **32** **I experience leg pain and cramps at night.**
- ☐ **33** **Sometimes I can't keep my legs still at night. I just have to move them to feel comfortable.**
- ☐ **34** **Even though I slept during the night, I feel sleepy during the day.**

Scoring

Questions 1-12: If you marked three or more boxes, you show symptoms of *Sleep Apnea* – a potentially serious disorder which causes you to stop breathing repeatedly, often hundreds of times in the night during your sleep.

Questions 13-19: If you marked three or more boxes, you show symptoms of *Insomnia* – a persistent inability to fall asleep or stay asleep.

Questions 20-27: If you marked three or more boxes, you show symptoms of *Narcolepsy* – a life long disorder characterized by uncontrollable sleep attacks during the day.

Questions 28-34: If you marked three or more boxes, you show symptoms of *Periodic Limb Movement Disorder* uncontrollable leg or arm jerks during sleep or *Restless Leg Syndrome* – uncomfortable feelings in the legs at night.

GREENVILLE HEALTH SYSTEM

GHS WOMEN'S HEART CENTER
ADDITIONAL FITNESS AND NUTRITION INFORMATION

1. In general compared to other women your age, rate how physically fit you are:
   1 2 3 4 5 6 7 8 9 10
   Not at all physically fit — Somewhat physically fit — Extremely physically fit

2. How much hard physical work is required on your job?
   ☐A great deal ☐A moderate amount ☐A little None

3. How long have you exercised or played sports regularly?
   ☐I do not exercise regularly ☐Less than 1 year ☐1-2 years
   ☐2-5 years ☐5-10 years ☐More than 10 years

4. On average, how many minutes of the week do you do vigorous-intensity aerobic physical activity?
   ☐None ☐30-60 ☐60-90 ☐90-120 ☐150 or more

5. On average, how many days a week do you do resistance/stretching training? (weight lifting, use of bands)
   ☐None ☐1-2 ☐3-4 ☐5-6 ☐7

6. On average, how many servings of fruit do you eat <u>per day</u>, (one serving = 1 Medium apple, banana, orange, etc.; ½ cup of chopped, cooked, or canned fruit, ¾ cup of fruit juice?)
   ☐None ☐1 ☐2 ☐3 ☐4 or more

7. On average, how many servings of vegetables do you eat <u>per day</u>, (one serving = ½ cup cooked or chopped raw, 1 cup raw leafy, ¾ cup vegetable juice?)
   ☐None ☐1-2 ☐3 ☐4 ☐5 or more

8. On average, how many servings of grains: bread, cereal, rice, or pasta do you eat <u>per day</u>, (one serving = 1 slice of bread, 1 ounce ready to eat cereal, ½ cup of cooked cereal, rice or pasta?)
   ☐None ☐1-3 ☐4-6 ☐7-9 ☐10 or more

9. When you use grain and cereal products, do you emphasize:
   ☐Whole grain, high fiber ☐Whole grain and refined ☐Refined, low fiber

10. On average, how many servings of <u>whole grains</u> do you eat <u>per week</u>?
    ☐None ☐1 ☐2 ☐3 ☐4 or more

11. On average, how many servings of red meat do you eat <u>per week</u>?
    (One serving = 2-3 ounces of steak, roast beef, lamb, ham, hamburger, etc.).
    ☐None ☐1 ☐2 ☐3 ☐4 or more

12. On average how many servings of chicken, turkey, and lean pork do you eat <u>per week</u>?
    (One serving = 3 ounces of meat).
    ☐None ☐1 ☐2 ☐3 ☐4 or more

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13. On average how many servings of fish do you eat per week, (One serving = 3.5 ounces?)
☐None ☐1 ☐2 ☐3 ☐4 or more
Give examples: ____

14. On average how many servings of cooked dry beans, peanut butter, or nuts do you eat per week, (one serving =, ½ cup of cooked dry beans, 2 tablespoons of peanut butter, or 1/3 c. nuts?)
☐None ☐1 ☐2 ☐3 ☐4 or more

15. On average how many servings of dairy products do you eat per day, (One serving = 1 cup of milk or yogurt, 1.5 ounces of natural cheese or 2 ounces of processed) cheese?
☐None ☐1 ☐2 ☐3 ☐4 or more

16. When you use dairy products, do you use:
☐Regular ☐Low fat ☐Nonfat

17. How many servings of fats and oils per week, regular salad dressings, butter or margarine, mayonnaise and vegetable oils?
☐None ☐1-3 ☐4-6 ☐7-9 ☐10 or more

18. How many egg yolks per week, regular salad dressings, butter or margarine, mayonnaise and vegetable oils?
☐None ☐1-3 ☐4-6 ☐7-9 ☐10 or more

19. How many servings of alcohol per day, week, or month, or none?
(4 ounces of wine, 12 ounces of beer, 1.5 ounces of 80-proof spirits, or 1 ounce of 100-proof spirits)
None ☐per day ☐per week ☐per month
☐1 ☐2 ☐3 ☐4 or more

20. On average how much sodium do you consume in a day?
(one teaspoon equals 2,400mg. Please look back at food labels if you have the time)
☐1,000mg ☐2,000mg ☐3,000mg ☐4,000mg or more

21. How many sweetened foods or beverages do you eat per week? ☐per week
(candy, soda, fruit drinks, coffee drinks or sweetened tea, desserts)
Please list specifics: ________________________________

22. How often do you order meals from restaurants or cafeterias per week, take-out or eat-in?
☐None ☐1-3 ☐4-6 ☐7-9 ☐10 or more

Nutrition Assessment for Two Days

Include meals, snacks, and drinks. Please answer honestly! Include portion size estimate as best you can such as cups, ounces, handful, ml, small medium or large, etc.

Typical Day on weekend

Morning____snack____________
Afternoon____snack____________
Evening____snack____________
Bedtime____snack____________

Typical Day during the week

Morning____snack____________
Afternoon____snack____________
Evening____snack____________
Bedtime____snack____________