THYROID INSTITUTE OF UTAH – PATIENT INFORMATION FORM

Please Print Clearly and Fill Out Completely

Patient Name _____
Last Name First Name M.I Maiden

Mailing Address _____
Street City State Zip

Home Phone (____) _____

Work Phone (____) _____

Cell Phone (____) _____

Preferred Phone:
☐ Home
☐ Work
☐ Cell

Email _____

Employer _____

Physician who sent you (First & Last Name) _____

Primary Care Physician (First & Last Name) _____

Gender - ☐ Male ☐ Female

Marital Status _____

Date of Birth _____ / _____ / _____

SSN# _____

Preferred Language (if not English) _____

PARENT or RESPONSIBLE PARTY (if patient is under the age of 18 or under the guardian care of a third party)

Name _____
Last Name First Name M.I. Maiden

Address _____
Street City State Zip

Home Phone (____) _____

Work Phone (____) _____

Cell Phone (____) _____

Patient's Relationship to the Responsible Party _____

Gender - ☐ Male ☐ Female

Date of Birth _____ / _____ / _____

SSN# _____

Employer _____

Employment Status - ☐ Full-time or ☐ Part-time

Other Parent's Name _____

INSURANCE INFORMATION (Despite our scanning your insurance card, please fill in all fields)

Primary Insurance:

Insurance Company _____
Ins. Address _____
Subscriber's Name _____
Subscriber's Date of Birth _____ / _____ / _____
Subscriber's ID# _____
Group# _____
Patient's Relationship to Subscriber _____

Secondary Insurance:

Insurance Company _____
Ins. Address _____
Subscriber's Name _____
Subscriber's Date of Birth _____ / _____ / _____
Subscriber's ID# _____
Group# _____
Patient's Relationship to Subscriber _____

EMERGENCY CONTACT (Not living with you)

Name _____ Relationship _____ Phone (____) _____
Address _____

RELEASE OF MEDICAL INFORMATON – By signing below, I authorize the doctors and staff at the Thyroid Institute and its affiliates to disclose my protected health information, including but not limited to office notes, diagnostic tests, and lab results, to the below-named persons (e.g., spouse or parent). This authorization shall be effective until I revoke it in writing.

Individual #1 _____ Individual #2 _____

Relationship to Patient _____ Relationship to Patient _____

FINANCIAL POLICY & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES – I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. **I understand co-payments are due at time of service.** I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, I am responsible for a collection fee of up to 40% of the principal amounts owing as allowed by Utah Code Annotated, sec. 12-1-11 in addition to any other amounts, such as interest or court costs. **I understand that some medical services performed in the office (ultrasounds, biopsies, blood tests, etc.) are billed separately from the office visit.**

By signing below, I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. Furthermore, I have read the Financial Policy above and agree to abide by its guidelines.

_____
Patient or Patient's Representative Signature Date

If signed by Representative, state name of: Representative _____ Relationship to Patient _____

PATIENT MEDICAL HISTORY FORM

Name:_____ Age:_____ Date of Birth_____/_____/_____ Marital Status: _____

Date symptoms started:_____ Primary reason for visit:_____

MEDICAL HISTORY *(check all that apply)*

☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Heart disease
☐ Stroke
☐ Osteoporosis
☐ Depression/Anxiety
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Thyroid nodules
☐ Parathyroid disorder
☐ Cancer *(list type)*_____

Last eye exam:_____

LIST ALL DIAGNOSED MEDICAL CONDITIONS

_____

_____

_____

_____

_____

LIST ALL PREVIOUS SURGERIES:

☐ Thyroidectomy: *(date)*_____

☐ Parathyroidectomy: *(date)*_____

_____

_____

_____

_____

SOCIAL HISTORY *(check all that apply)*

☐ Alcohol use: _____ drinks per week ☐ No Alcohol use

☐ At risk for HIV infection (unprotected sex, IV drug use, history of blood transfusions)

☐ History of drug use

Smoking Status: ☐ Current If current: ____ packs per day

☐ Former (when quit: _____) ☐ Never smoked

Second hand smoke exposure:

☐ Environmental ☐ Occupational ☐ Perinatal/before birth

☐ Tobacco use (other/chew): _____

LIST CURRENT MEDICATIONS & SUPPLEMENTS:

(use back of this form for more space)

Name	Dose	Frequency	Route

Preferred Pharmacy:_____

(Name, City)

LIST ALLERGIES TO MEDICATIONS: ☐ No Known Allergies

_____

_____

FAMILY HISTORY *(check if blood relatives have the following)*

DISEASE	RELATIONSHIP TO YOU
☐ Diabetes	_____
☐ Thyroid/Parathyroid disorders	_____
☐ Thyroid cancer	_____
☐ Other cancer	_____
☐ Heart disease	_____
☐ Bleeding tendency	_____

FEMALE PATIENTS ONLY:

Last menstrual cycle: _____

Age of first period: _____

Number of days between cycles: _____

Number of pregnancies: _____

Number of living children: _____

Number of miscarriages: _____

REVIEW OF SYSTEMS
PLEASE CIRCLE 'YES' or 'NO' FOR ALL ITEMS BELOW
(Problems you have had within the past 3 months)

ALLERGY/IMMUNE
Yes No Hayfever
Yes No Swollen glands or nodes
Yes No Weak immune system

CARDIOVASCULAR
Yes No Chest pain
Yes No High blood pressure
Yes No Palpitation or heart racing
Yes No Swelling in legs or feet

EARS
Yes No Ear aches
Yes No Ear infections
Yes No Hearing problems
Yes No Tinnitus
Yes No Vertigo

ENDOCRINE
Yes No Breast discharge
Yes No Diabetes
Yes No Excessive thirst
Yes No Heat or cold intolerance
Yes No Thyroid problems

EYES
Yes No Blurry vision
Yes No Double vision
Yes No Glasses or contacts
Yes No Glaucoma

GENERAL
Yes No Fatigue
Yes No Fever
Yes No Loss of appetite
Yes No Night sweats
Yes No Recent weight change

GASTROINTESTINAL
Yes No Abdominal pain
Yes No Blood in stool
Yes No Constipation
Yes No Diarrhea
Yes No Difficulty swallowing
Yes No Heartburn
Yes No Nausea or vomiting

GENITOURINARY
Yes No Blood in urine
Yes No Frequent urination
Yes No Kidney stones
Yes No Loss of bladder control

HEMATOLOGIC/LYMPH
Yes No Anemia
Yes No Blood transfusions
Yes No Easy bruising or bleeding

INTEGUMENTARY (Skin)
Yes No Changes in hair or nails
Yes No Dryness
Yes No New stretch marks
Yes No Rashes

MOUTH and THROAT
Yes No Dry mouth
Yes No Frequent sore throats
Yes No Sore tongue

MUSCULOSKELETAL
Yes No Back pain
Yes No Muscle cramps
Yes No Muscle weakness
Yes No Neck pain
Yes No Swelling or pain in joints

NEUROLOGIC
Yes No Frequent headaches
Yes No Head injury
Yes No Loss of consciousness
Yes No Numbness around mouth
Yes No Numbness or tingling
Yes No Seizures
Yes No Tremors

NOSE and SINUSES
Yes No Frequent colds
Yes No Nasal stuffiness
Yes No Sinus troubles

PSYCHIATRIC
Yes No Anxiety
Yes No Depression

RESPIRATORY
Yes No Asthma
Yes No Frequent cough
Yes No Shortness of breath
Yes No Spitting up blood
Yes No Wheezing

I have reviewed the above and circled all symptoms which apply.

Patient Name:_____
Date of Birth:_____
Today's Date:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE OF BIRTH**:_____ **TODAY'S DATE**:_____

☐ Put your initials in this box if you decline to provide this information today

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(please circle your answers)*

	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	+	+
		TOTAL:		

10. If you circled 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? *(please check one)*

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

For Doctor Use Only

- ☐ Based on today's screening, clincial depression is not noted. No follow-up plan needed.
- ☐ Based on today's screening, clincial depression is indicated. Patient is being referred to _____ for follow up treatment.
- ☐ Based on today's screening, clincial depression is indicated. Patient is already under the care of his/her PCP for treatment of clinical depression.
- ☐ Patient declined to take clinical depression screening today.