Pre-Employment Physical

Please contact Family Health Center at 208-263-1435 option #2 to schedule your pre-employment physical. We will coordinate your Physical Capacity Appointment and Doctors Appointment and we'll find a time that works best for you.

Please complete the attached forms and return them to Family Health Center prior to your appointment. You will also need to bring your ID with you to your appointment.

Forms to be completed:

- ☐ Family Health Center New Patient Paperwork
- ☐ Idaho Forest Group Medical Form
- ☐ Physical Capacity Evaluation Form (to be completed at your appointment)

Forms to be returned to:

- ☐ Idaho Forest Group – Laclede Fax # 208-265-6527
- ☐ Idaho Forest Group – Moyie Fax # 208-255-3286

Providers: Please return all completed form to the Front Desk

IDAHO FOREST GROUP

MEDICAL HISTORY

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Social Security Number: _____

We are an Equal Opportunity Employer and the information requested below shall not be used for any discriminatory purpose with respect to hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, as prohibited by applicable, local, state or federal law.

History of previous illnesses/injuries - Have you ever had any of the following:

		YES	NO			YES	NO			YES	NO
1	Back injuries or disorders			14	Asthma/Chronic bronchitis			27	Cerebral Palsy		
2	Shoulder injuries or disorders			15	Allergies or hay fever			28	Rheumatic fever		
3	Knee injuries or disorders			16	Allergies to wood dust			29	Parkinson's Disease		
4	Head injuries or Brain injury			17	Reaction to serum, drug or medicine			30	Multiple Sclerosis		
5	Other fractures/injuries			18	High Blood Pressure			31	Rheumatism or gout		
6	Muscular disorders			19	High Cholesterol			32	Frequent or severe headaches		
7	Heart/Cardiovascular/Surgery			20	Blood clots			33	Fainting or dizziness		
8	Lung Disorders/Emphysema			21	Varicose veins or leg ulcers			34	Epilepsy/convulsions/seizures		
9	Ear disorder/Loss of hearing/Balance			22	Anemia			35	Psychiatric disorders/depression		
10	Sore wrists/tendonitis/carpal tunnel			23	Hemophilia			36	Eye disorders/impaired vision		
11	Arthritis/Joint disorders			24	Hernia or rupture			37	To be hospitalized		
12	Stroke or paralysis			25	Diabetes			38	Chest x-rays		
13	Cancer			26	Kidney disease/dialysis			39	Operations/Surgeries		

If you answered YES to any of the previous questions, please explain (Give onset date, name of treating physician, treatment, any current limitations; use reverse of form if more space needed):

_____

_____

Primary Care Physician: _____ Phone Number: _____

Present Medications (including prescribed and over-the-counter): _____

_____

Are you currently pregnant? YES / NO If so, how many months? _____

Do you use any tobacco/nicotine products? YES / NO If so, what is the frequency? Light _____ Moderate _____ Heavy _____

Is there any condition, of which you are aware, that would not allow you to exert maximally during portions of this physical fitness test? List any physical limitations of which you are aware: _____

_____

Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I authorize the release of medical information contained in this history and medical examination to the employer shown above. I further certify that the statements made above are accurate to the best of my knowledge. I understand that any misrepresentation is sufficient cause for dismissal.

Applicant Signature: _____ Date: _____

606 N. 3rd Ave Suite 101
Sandpoint, ID 83864
Ph#208.263.1435
Fax# 208.263.4580
www.fhcsandpoint.com

Family Health Center

Scott Dunn, MD
Zach Halversen, MD
Jane Hoover, FNP
Dan Meulenberg, MD
Hannah Raynor, MD
Jeremy Waters, MD
Kara Waters, DO

Please complete the following paperwork and return to us 24 hours prior to your appointment.

Adult New Patient Paperwork

Last Name:	First Name:	MI:	DOB:
Previous Last Name (Maiden):	Nickname:		
SSN:	Age:	Gender: ☐ M ☐ F	
Mailing Address:	City:	St:	Zip:
Home Phone:	Cell Phone:		
Occupation:	Employer:	Ph#:	
Insurance:	Policy #:		
E-Mail Address:			
Preferred Language:	Disabled: ☐ Y or ☐ N	Veteran: ☐ Y or ☐ N	
Hearing impairment: ☐ Y or ☐ N	Vision Impairment: ☐ Y or ☐ N	Memory Impairment: ☐ Y or ☐ N	

Marital Status	**Preferred Contact**	**Ethnicity**	**Race**
☐ Married	☐ Mail	☐ Hispanic/Latino	☐ American Indian or Alaskan Native
☐ Single	☐ Home Phone	☐ Non-Hispanic	☐ Asian
☐ Divorced	☐ Cell Phone		☐ Black or African American
☐ Separated	☐ Patient Portal		☐ Native Hawaiian/Other Pacific Islander
☐ Widowed	☐ E-Mail		☐ White
☐ Life Partner			☐ Other

How would you like us to remind you about your future appointments? (choose one)

☐ Voice Reminder (# we should call) _____

☐ Text message (# we should text) _____ *(Data message rates may apply-contact your carrier)*

☐ E-mail _____

Spouse / Significant Other / Emergency Contact/Support Person

Last Name:	First Name:	MI:	DOB:
SSN:	Age:	Gender: ☐ M ☐ F ☐ Other	
Mailing Address:	City:	St:	Zip:
Home Phone:	Cell Phone:		
E-Mail Address:			
Occupation:	Employer:	Ph#:	
Relationship to patient:			

How did you hear about us? ☐Employer ☐Family Member ☐Friend ☐Google/Web ☐Insurance Co ☐Previous Patient ☐Referral

☐ Other: _____

Consent for treatment:

I do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians of Family Health Center to me. I certify that, to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also authorize Family Health Center to release information requested by insurance companies and/or its' representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Printed Name of Patient/Guardian Date

Acknowledgement of Notice of Health Information Practices

This Notice explains when we might use/disclose your health information, and includes some of the following examples:

When you give us permission to disclose your health information

- To aid in your treatment or to persons involved in your health care
- To help us or other health care providers get paid for services provided to you
- To public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Notice also explains some of your rights under HIPAA, including but not limited to your:

- Right to ask that information about you not be disclosed to certain persons
- Right to restrict disclosures of PHI to your health plan when you pay out of pocket in full for a healthcare item or procedure
- Right to ask that we communicate differently with you to ensure your privacy
- Right to look at and get a copy of most of your health information in our records
- Right to request that we correct health information in your record that is wrong or misleading
- Right to be notified when a breach of your health information has occurred
- Right to have us tell you whom we have disclosed your health information
- Right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services

I acknowledge that I have been given an opportunity to review this facility's Full Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have. (*This is NOT the complete Notice of Health Information Practices. If you would like the full copy it is available by request or by visiting our website at www.fhcsandpoint.com.)*

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Printed Name of Patient/Guardian Date

Patient Name: _____ **DOB:** _____

Main reason for your upcoming visit: _____

Which pharmacy will you be using? _____

Do you have a POST/Advance Directive? ☐ Yes ☐ No

Do you have a designated Durable Power of Attorney? ☐ Yes ☐ No If yes, who? _____

For female patients – Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Medications – List all medications you take, prescription and non-prescription, and the dosage

Medication Name	Dosage	Frequency

Medication & Food Allergies – List all known allergies (drugs, food, animals, etc.)

Allergy	Reaction

Health Maintenance – Check if you have received the following, and the date of most recent exam

Exam	Date	Normal or Abnormal?	Exam	Date	Normal or Abnormal?
Colonoscopy			Foot Exam (if Diabetic)		
DEXA Scan			Lipid Panel		
Echocardiogram			Mammogram		
EKG			PAP Test (Female only)		
Eye Exam (if Diabetic)			Physical/Wellness Exam		
			Birth Control & Type		

Vaccine	Date Received	Vaccine	Date Received
Influenza (Flu)		Shingles	
Pneumonia ☐ 13, ☐ 23		Tetanus	

Medical History – Check if you have ever had or do have any of the following, and year of onset			
Condition	**Year Diagnosed**	**Condition**	**Year Diagnosed**
Allergies - What Kind? _____		☐ Diabetes - Type 1 or 2	
☐ Anxiety		☐ Heart Attack	
☐ Arthritis		☐ High Cholesterol	
☐ Asthma		☐ High Blood Pressure	
☐ Blood Clots – Where? _____		☐ Osteoporosis	
☐ Cancer – What Type? _____		☐ Renal Disease – Stage? _____	
☐ Coronary Artery Disease		☐ Stroke	
☐ COPD		☐ Thyroid Disorder	
☐ Crohn's Disease		☐ Other:	
☐ Depression		☐ Other:	

Surgical History – Check if you have received the following procedures, and year performed					
☐ *None*					
Surgical Procedure	**Year Completed**	**Outcome of Surgery**	**Surgical Procedure**	**Year Completed**	**Outcome of Surgery**
☐ Appendectomy			***Female Only***		
☐ Back Surgery			☐ Breast Biopsy		
☐ Heart Surgery			☐ Cesarean Section		
Type:			☐ Mastectomy		
☐ Hernia Repair			*Cancerous:*		
Type:			☐ Hysterectomy		
☐ Knee Surgery			*Cancerous:*		
Type:			*If Hysterectomy – what kind?*		
☐ Tonsillectomy			☐ Total, removal of both tubes and ovaries	☐ Total, unilateral of tube and ovary	
Male Only			☐ Radical	☐ Total	☐ Vaginal
☐ Vasectomy					
☐ Other:					

Family History – Check if any family member(s) has had any of the following conditions and age of onset

Are you adopted? ☐ Yes ☐ No

Relationship to you	Alzheimer's	Anxiety	Alcoholism	Asthma	Blood Disorder	Depression	Diabetes	Heart Attack	Heart Failure	Hypertension	High Cholesterol	Renal Disease	Schizophrenia	Stroke	Thyroid Disorder	Cancer – list type and age below	**Alive?** *Mark Yes or No*
Father Age of onset?																	Cause of death and age:
Mother Age of onset?																	Cause of death and age:
Sister(s) Age of onset?																	Cause of death and age:
Brother(s) Age of onset?																	Cause of death and age:

Social History

Do you have any children? ☐ Yes ☐ No If Yes, How many: Male(s) _____ Female(s)

Who do you live with? _____ Spouse _____ Child _____ Caregiver _____ Other

Do you use tobacco? ☐ Yes ☐ No If Yes, age started: _____ If former, age quit: _____

If Yes, or if former user, what kind and how often?

☐ Cigarettes - _____packs/day ☐ Chew- _____cans/day ☐ Cigars- ____/day ☐ E-cigs- _____/day ☐ Pipe

Have you been / are you currently exposed to second hand smoke? ☐ Yes ☐ No

What Kind? _____ For how long have you been/were you exposed? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____/day/week/month

When was your last drink? _____ What kind? _____

Do you drink caffeine? ☐ Yes ☐ No How much? _____

If yes, what type? ☐ Coffee ☐ Tea ☐ Energy drinks ☐ Soda

Do you exercise? ☐ Yes ☐ No How often? _____

If yes, what type of exercise do you do? _____

Have you/do you use recreational or street drugs? ☐ Yes ☐ No ☐ Previously

If yes, what kind: ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Opioids ☐ Speed ☐ Other _____

How hard is it for you to obtain the very basics like food, housing, heating and medical care?

☐ Very hard ☐ Hard ☐ Somewhat hard ☐ Not very hard

How often do you get together with friends or relatives? _____ times per week/month/year _____ Never

Patient Health Questionnaire (PHQ-9)				
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 every day
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching tv				
h. 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.				
i. Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off any problem on this questionnaire so far, how difficult have these problems made if 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

Is there anything else you would like to know about your medical history?

_____

_____

_____

_____

Thank you for choosing Family Health Center to provide you with your medical care. We look forward to getting to know you and your family!