ADVENT INTERNAL MEDICINE

George G. Kim, MD and Jeremey Pettit, PA-C

Dear Patient,

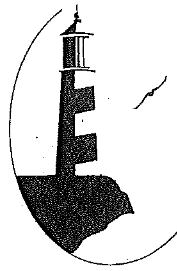
We at Advent Internal Medicine would like to take this opportunity to welcome you to our practice. Included in this packet are several documents that will need to be filled out, front and back, before your appointment can be made. Enclosed you will also find a brief letter of introduction about Dr. Kim. Once completed, please return these forms and bring the following items when scheduling:

1. Insurance Card(s)
2. Driver's License or Picture ID
3. A list of all doctors's which you have seen in the past three years, their names and phone numbers.
4. Any and all medical records that are available for Dr. Kim to review ***prior*** to your visit. (DO NOT BRING THE DAY OF VISIT)

At the time of your visit with Dr. Kim, please bring ALL medications, in their bottles, that you are currently taking.

As a courtesy to all of our patients we strive to be on time, therefore if you arrive more than TEN minutes late we will need to reschedule your visit. For missed appointments without sufficient notification, 24-hours advanced notice, there will be $50.00 rescheduling fee for first-time appointments and a $25.00 fee for regularly scheduled appointments. We look forward to getting to know you and pray that you have good physical, mental and spiritual health.

Sincerely,
The Advent Internal Medicine



George G. Kim, MD was born in Seoul, South Korea, the son of a Pathologist. When he was four years old, his family moved to the United States where his father worked in cancer research in Buffalo, New York. Dr. Kim received his undergraduate degree from Trinity University in San Antonio, Texas. As an undergraduate, Dr. Kim completed a double major in biophysics and biology. His doctor of medicine degree is from Loma Linda University School of Medicine in California. He completed his Internal Medicine residency at Kettering Medical Center in Dayton, Ohio, which is affiliated with Wright State University, and achieved board certification in 1997. He began his practice through Park Ridge Hospital from 1997-2003. He was then in partnership with Dr. Bill Casp in Rutherfordton from 2003-2004.

As of October 1, 2004, Dr. Kim has established a private practice - **Advent Internal Medicine** - in Lynn, NC, which was between the towns of Columbus and Tryon. His desire is to build strong ties with the community, its health care system and St. Luke's Hospital. In his spare time, Dr. Kim enjoys tennis, archery, volleyball, choir, guitar, backpacking and playing with his two children.

Dr. Kim's faith in God has played an important role in his professional and personal choices. He stated, "Healing in partnership with God helps people realize how deeply He cares for our pain, emotions, health and happiness."

Internal Medicine specialist treat not only the routine care of basic medical/primary care needs of patients age 15 to end of life issues, but also is involved in critical care and complex multi-organ diseases and even critical care specialty needs of patients.

Dr. Kim is accepting new patients, please call (828) 859-7659 for an appointment.

ADVENT INTERNAL MEDICINE

George G. Kim, MD
Jeremy Pettit, PA-C

Patient Information

Patient Name: ____
First Middle Last

Date of Birth: ____-____-_______ Social Security Number: ____-____-______ Marital Status: ___________

Address: ____
Street Apartment #

____
City State Zip Code

Home Phone: (____)_____-_______ Cell Phone: (____)_____-_______ Work Phone: (____)_____-_______

Employer:_______________________________ Occupation/Position: ___________________________

Insurance Name:_______________________________ Policy Number:_____________________________

Group Number:__________________ Email Address: ___________________________

Responsible Party Information (If Other Than Patient)

Responsible Party Name: ____
First Last

Address: ____
Street Apartment #

____
City State Zip Code

Home Phone: (____)_____-_______ Other Phone: (____)_____-_______ Relationship to Patient: __________

Spouse Information

Spouse's Name: ____
First Middle Last

Date of Birth: ____-____-_______ Social Security Number: ____-____-______

Cell Phone: (____)_____-_______ Work Phone: (____)_____-_______

Emergency Contact (If Other Than Spouse)

Contact Person's Name: ____
First Last

Home Phone: (____)_____-_______ Cell Phone: (____)_____-_______ Work Phone: (____)_____-_______

ADVENT INTERNAL MEDICINE

George G. Kim, MD & Jeremy Pettit, PA-C

FINANCIAL POLICY

Private Insurance

To help us provide the most efficient and reasonable health care services, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided by Dr. Kim. It is our policy to file claims for insurance as a courtesy to you if we have accurate and complete insurance information. **The balance due is still your responsibility if we still have not received payment from your insurance company within 30 days.** Therefore, you may receive a bill after the 30 days. If we receive duplicate payment from the insurance company, we will then prepare a refund for any overpayment and send it to you.

Medicare

For all Medicare patients, we will file your Medicare and supplementary insurance; you will be billed for any remaining balance due. Since we are not a party to the agreement between you and your supplementary insurance company, we ask that you assist us in contacting them if they have not paid for our services within 30 days of payment from Medicare. Any duplicate payment by you and your insurance carrier will be refunded to you.

Cash

If you do not have any insurance you will be considered a "Self-Payment" patient. Financial arrangements are required at the time of services and you are required to keep your account in good standings at all times.

We ask that you attempt to help us by keeping in touch with us at all time on the status of your account.

I the undersigned understand and comply with this financial policy and understand that the original copy will be kept in my permanent record. A copy of this document will be made for me upon my request.

________________________________ __________________

Patient of Responsible Party Signature *Date*

ADVENT INTERNAL MEDICINE

George G. Kim, MD & Jeremy Pettit, PA-C

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Persons Authorized to Receive Information:
Health information that George G Kim, MD collects or receive about you may be disclosed to the following persons:

Name of Referring Physician (if applicable): ______________________________

Name of Person/Family/Organization: ______________________________

Name of Person/Family/Organization: ______________________________

Use of Disclosure of Information:
_____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided by George G. Kim, MD. (I understand that Advent Internal Medicine may ask for identification of the person picking up patient medical information or products on my behalf to ensure the privacy of my health information.)

_____ I do not authorize the following information to be disclosed to any other parties except to me as the patient.

Expiration Date of Authorization:
This authorization will be permanently in effect unless revoked or terminated in writing by the patient or patient's personal representative.

Right to Terminate of Revoke Authorization:
You may revoke or terminate this authorization by filling out and signing a form at Advent Internal Medicine.

Potential for Re-disclosure:
The person or organization to which health information is sent, may repeatedly disclose health information that is identified by this authorization The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (Please Print): ______________________________

Signature of Patient: ______________________________ Date: ______________

Signature of Patient Representative: ______________________________

Relationship of Patient Representative to Patient: ______________________________

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Appointment Reminders:
This office may use your information to remind you about your upcoming appointments. Typically, appointment reminder cards are given to you in the office at the time of scheduling. However, it is the patient's responsibility to keep track of all appointments and may call at any time if there are any questions.

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided George G. Kim, MD and/or Jeremy Pettit, PA-C.
(Please Check All That Apply)

- ☐ **US Mail**
- ☐ **Home Phone**
- ☐ **Cell Phone**
- ☐ **Work Phone**
- ☐ **Appointment Card**

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare?
(Please Check One)

- ☐ **Yes**
- ☐ **No**

If 'No' how else may we contact you regarding this information?

Please list any other restrictions regarding messages or reminders about your healthcare:

JOINT NOTICE OF CONSENT FOR MEDICAL TREATMENT, INSURANCE ASSIGNMENT AND GUARANTEE OF PAYMENT

Patient's Full Name: ________________________________ **Date of Birth:** ____/____/______

CONSENT FOR MEDICAL TREATMENT

I voluntarily consent to medical treatment and diagnostic procedures provided by George G. Kim, MD. I consent to the testing for infectious disease, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

INSURANCE ASSIGNMENT

I the undersigned, herby authorize *Advent Internal Medicine*, to apply for benefits on my behalf for covered services rendered to me. **I REQUEST PAYMENT FROM MY INSURANCE CARRIER, IF ANY, BE MADE DIRECTLY TO ADVENT INTERNAL MEDICINE**, unless otherwise indicated on the claim. I certify that the information reported with regard to insurance coverage is correct and further authorized the release of any necessary information, including medical information for this or any related claim to my insurance carrier. In making this assignment, I understand and agree that I am financially responsible for charges not paid under this insurance policy.

GUARANTEE OF PAYMENT

To *Advent Internal Medicine*--For and inconsideration of services rendered, or to be rendered to the above named patient, I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. I agree with and authorize *Advent Internal Medicine* or contracted billing service to take all lawful steps available to collect funds from me to secure its financial interest. In the event the account must be placed with an attorney or collection agency to obtain payment, I agree that jurisdiction for said collection shall bE Polk County, North Carolina; that I shall pay full amount of court fees; interest of the judgment balance at the rate of eight percent. I also agree to meet with representatives of *Advent Internal Medicine* or contracted billing services to established a payment plan, and agree to provide *Advent Internal Medicine* or contracted billing service with all request information pertaining to personal and family earnings and expenses. (*i.e,. copies or recent 1040 forms, employment pay stubs, etc.)

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS AND HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS. At any time if I wish to have a copy of this form one will be provided to me by *Advent Internal Medicine*.

________________________________ ________________________
Signature Date

________________________________ ________________________
Advent Internal Medicine Witness Date

Advent Internal Medicine

George G. Kim, MD and Jeremy Pettit, PA-C

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a legal record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal documentation describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided

Understanding what is in your record and how your health information is used helps you to:

- Comprehend your privacy rights
- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

1. **Obtain copy of Notice of Privacy Practices.** You are entitled to receive a paper copy of our notice of privacy practices. You will be offered a copy when first filling our new patient packet and may ask for another copy at any time.
2. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make written request to the contact person listed at the bottom of this policy. Specify the requested method of contact, or location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
3. **Requesting Restrictions 45 CFR 164.552.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations.

Additionally, you have the right to request that we restrict our disclosure of your protected health information (PHI) to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do not agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the contact person listed at the bottom of this policy. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

4. **Inspection and Copies 45 CFR 164.524.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the contact person listed at the bottom of this policy in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying associated with your request.
5. **Amendments 45 CFR 164.528.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or our practice. To request an amendment, your request must be made in writing and submitted to the contact person listed at the bottom of this policy. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
6. **Accounting of Disclosure 45 CFR 164.528.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the contact person listed at the bottom of this policy. Our practice will notify you of the cost involved with additional requests, and you may withdraw your request before your incur any costs.
7. **Fundraising.** Our patients have the right to opt out of receiving fundraising communications.
8. **Paying Out of Pocket.** When the patient pays out of pocket for a service provided, at the patients request, our practice agrees to restrict the disclosure of PHI.
9. **Breach Notification.** Patients have the right to be notified when a breach of his or her unsecured PHI has occurred.

10. **Use and Disclosure Requiring Authorization.** Use or disclosure of protected health information for marketing purposes will require the patients authorization.

How We Use Your Patient Health Information (PHI)
We use health information about your treatment, to obtain payment and for healthcare operations, including administrative purposes and evaluation of the quality of care that you receive. This notice gives examples of how we will use or disclose your PHI for treatment, payment, and healthcare operations (TPO). The notice also describes circumstances when we may have to use or disclose the information even without your consent.

Examples of TPO Treatment: We will use and disclose your PHI to provide you with medical treatment of services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers such as hospitals, consulting physicians and nurses who are participating in your treatment, to pharmacists who are filling your prescriptions and to family members who are helping with your care.
Payment: We will use and disclose your PHI for payment purposes. For example we may use your PHI to obtain authorization from your insurance company or your employer before providing treatment or ordering testing. We will submit bills and maintain records of payment from your health plan.
Healthcare Operations: We will use and disclose your PHI to conduct our standard internal operations, including proper administration of records, evaluations of the quality of treatment and to assess the care and outcome of your case and other like it.
Special Uses: We may use your information to contact you with appointment reminders or changes.
Other Uses and Disclosures: We may use and disclose identifiable PHI about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give your PHI without your consent for the following purposes:

1. **Required By Law:** We may be required by law to report gunshots wounds, suspected abuses or neglect or similar injuries or events.
2. **Public Health Activities:** As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and other similar information to public health authorities.
3. **Health Oversight:** We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.
4. **Judicial and Administrative Proceedings:** We may disclose information in response to an appropriate subpoena or court order.
5. **Law Enforcement Purposes:** Subject to certain restrictions, we may disclose information required by law enforcement officials.
6. **Deaths:** We may report information regarding deaths to coroners, medical examiners, and funeral directors.
7. **Serious Threat to Health or Safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
8. **Military and Veterans:** If you are a member of the armed forces, we may release

information as required by military command authorities.

9. **Research:** We may use or disclose information for approved medical research as long as the data is reported with all identifying information removed.
10. **Workers' Compensation:** We may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.
11. **Drug and Alcohol Screens:** We may release results of drug and alcohol screens mandated by your employer to your employer's designated agent.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. You can also request a copy of our Notice at any time. For questions about our privacy practices, contact the person listed below.

Complains

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S, Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests or complaints, please contact, preferably in writing, the person listed below.

Office Manager
Advent Internal Medicine
11 Sunshine Lane
Columbus, NC 28722
(828) 859-7659

ADVENT INTERNAL MEDICINE

George G. Kim, MD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: ______________________________

Signature: ______________________________

Date: ________________

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

ADVENT INTERNAL MEDICINE

George G. Kim, M.D. and Jeremy Pettit, PA-C

Patient's Name: ________________________ Date of Birth: ___/___/_____ Today's Date: ___/___/_____

CONSTITIONAL SYMPTOMS

Good General Health Lately	□Yes	□No
Recent Weight Change	□Yes	□No
Fever	□Yes	□No
Fatigue	□Yes	□No
Headaches	□Yes	□No

EYES

Eye Disease or Injury	□Yes	□No
Wear Glasses/Contact Lenses	□Yes	□No
Blurred or Double Vision	□Yes	□No
Glaucoma	□Yes	□No

EARS/NOSE/MOUTH/THROAT

Hearing Loss or Ringing	□Yes	□No
Earaches or Drainage	□Yes	□No
Chronic Sinus Problems or Rhinitis	□Yes	□No
Nose Bleeds	□Yes	□No
Mouth Sores	□Yes	□No
Bleeding Gums	□Yes	□No
Bad Breath or Bad Taste	□Yes	□No
Sore Throat or Voice Change	□Yes	□No
Swollen Glands in Neck	□Yes	□No

RESPIRATORY

Chronic or Frequent Cough	□Yes	□No
Spitting Up Blood	□Yes	□No
Shortness of Breath	□Yes	□No
Asthma or Wheezing	□Yes	□No

GASTROINTESTINAL

Loss of Appetite	□Yes	□No
Change is Bowel Movements	□Yes	□No
Nausea or Vomiting	□Yes	□No
Frequent Diarrhea	□Yes	□No
Painful Bowel Movements or Constipation	□Yes	□No
Rectal Bleeding Or Blood in Stool	□Yes	□No
Abdominal Pain or Heart Burn	□Yes	□No
Peptic Ulcer (Stomach or duodenal)	□Yes	□No

GENITOURINARY

Frequent Urination	□Yes	□No
Burning or Painful Urination	□Yes	□No
Blood in Urine	□Yes	□No
Change in Force of Strain When Urinating	□Yes	□No
Incontinence or Dibbling	□Yes	□No
Kidney Stones	□Yes	□No
Sexual Difficulty	□Yes	□No
Male-Testicle Pain	□Yes	□No
Female-Pain with Periods	□Yes	□No
Female-Irregular Periods	□Yes	□No
Female-Vaginal Discharge	□Yes	□No

Female- # of Pregnancies _____ # of Miscarriages _____

Female-Date of last pap smear _____/_____/_____

Female-Age of first Pregnancy _____

Female-Date of Last Menstrual Period _____/_____/_____

CARDIOVASCULAR

Heart Trouble	□Yes	□No
Chest Pain or Angina Pectoris	□Yes	□No
Palpitations	□Yes	□No
Shortness of Breath while Walking/Lying Flat	□Yes	□No
Swelling of feet, ankles, or hands	□Yes	□No

INTEGUMENT (SKIN, BREAST)

Rash or Itching	□Yes	□No
Change in Skin Color	□Yes	□No
Change in Hair or Nails	□Yes	□No
Varicose Veins	□Yes	□No
Breast Pain	□Yes	□No
Breast Lump	□Yes	□No
Breast Discharge	□Yes	□No

NEUROLOGICAL

Frequent or Recurring Headaches	□Yes	□No
Light Headed or Dizzy	□Yes	□No
Convulsions or Seizures	□Yes	□No
Numbness or Tingling Sensation	□Yes	□No
Tremors	□Yes	□No
Paralysis	□Yes	□No
Stroke	□Yes	□No
Head Injury	□Yes	□No

PSYCHIATRIC

Memory Loss or Confusion	□Yes	□No
Nervousness	□Yes	□No
Depression	□Yes	□No
Insomnia	□Yes	□No

ENDOCRINE

Glandular or Hormone Problem	□Yes	□No
Thyroid Disease	□Yes	□No
Diabetes	□Yes	□No
Excessive Thirst or Urination	□Yes	□No
Heat or Cold Intolerance	□Yes	□No
Skin Becoming Dryer	□Yes	□No
Change in Hat or Glove Size	□Yes	□No

HEMATOLOGY/LYMPHATIC

Slow to Heal After Cuts	□Yes	□No
Bleeding/Bruising Tendency	□Yes	□No
Anemia	□Yes	□No
Plebitis	□Yes	□No
Past Blood Transfusion	□Yes	□No
Enlarged Glands	□Yes	□No

ALLERGIC/IMMUNOLOGIC

History of Skin Reaction or other Adverse Reaction to:

Penicillin or other Antibiotics	□Yes	□No
Morphine, Demerol, or other Narcotics	□Yes	□No
Lidocaine or other Anesthetic	□Yes	□No
Aspirin or other Pain Remedies	□Yes	□No
Tetanus antitoxin or other Serums	□Yes	□No

FAMILY HISTORY

Has any blood relative ever had any of the following:

Circle 'Yes' or 'No'		If so, what relationship:
Anemia	Yes No	______
Bleeding Tendency	Yes No	______
Leukemia	Yes No	______
Repeated Infections	Yes No	______
Crippling Arthritis	Yes No	______
Heart Disease	Yes No	______
Lung Disease	Yes No	______
Tuberculosis	Yes No	______
High Blood Pressure	Yes No	______
Kidney Disease	Yes No	______
Asthma	Yes No	______
Severe Allergies	Yes No	______
Mental Illness	Yes No	______
Convulsions or Fits	Yes No	______
Migraine Headaches	Yes No	______
Diabetes	Yes No	______
Gout	Yes No	______
Obesity	Yes No	______
Thyroid Trouble	Yes No	______
Peptic Ulcer	Yes No	______
Chronic Diarrhea	Yes No	______
Cancer (which kind)	Yes No	______

PAST HISTORY

Circle 'Yes' or 'No'

Have you ever had:		**Operations:**	
Measles	Yes No	Tonsils	Yes No
Mumps	Yes No	Gall Bladder	Yes No
Whooping Cough	Yes No	Stomach	Yes No
Polio	Yes No	Breast	Yes No
Scarlet Fever	Yes No	Uterus/Ovaries	Yes No
Meningitis	Yes No	Prostate	Yes No
Infectious Mono	Yes No	Hernia	Yes No
Tuberculosis	Yes No	Thyroid	Yes No
Exposure to TB	Yes No	Varicose Veins	Yes No
Bronchitis	Yes No	Hemorrhoids	Yes No
Pneumonia	Yes No	Heart	Yes No
Pleurisy	Yes No	Other	Yes No
Hepatitis	Yes No	**Allergies:**	
Yellow Jaundice	Yes No	Tetanus Vaccine	Yes No
Bladder Infections	Yes No	Penicillin	Yes No
Rheumatic Fever	Yes No	Sulfa	Yes No
Kidney Disease	Yes No	Other Drugs:	Yes No
Hives	Yes No	List: ______	
Hay Fever/Sinusitis	Yes No	______	
Asthma	Yes No	Foods	Yes No
Emphysema	Yes No	Cosmetics	Yes No
Arthritis	Yes No	Other	Yes No
Back Trouble	Yes No	**Immunizations:**	
High Blood Pressure	Yes No	Small Pox	Yes No
Heart Disease	Yes No	Tetanus	Yes No
Anemia	Yes No	Polio Shots	Yes No
Bleeding Disorder	Yes No	Polio Oral	Yes No
Ulcer	Yes No	Pneumonia	Yes No
Cancer	Yes No	Influenza	Yes No
Hemorrhoids	Yes No	Hepatitis B	Yes No
Blood Transfusion	Yes No	Shingles	Yes No
HIV/AIDS	Yes No	Other:	Yes No

FAMILY MEMBERS

	Present Age Or Age at Death	**Health Problems, Cause of Death**
Father	______	______
Mother	______	______
Brother	______	______
Brother	______	______
Brother	______	______
Sister	______	______
Sister	______	______
Sister	______	______
Child	______	______
Child	______	______
Child	______	______
Child	______	______
Child	______	______

SOCIAL HISTORY

Check the one that best applies:

Marital Status ☐S ☐M ☐D ☐W ☐Sep

Use of Alcohol ☐No ☐Rarely ☐Moderately ☐Daily

Use of Tobacco ☐No ☐Previously, but Quit ☐Yes

Use of Street Drugs ☐No ☐Yes/type:______

Religion: ______ Nationality: ______

Occupations: ______

Exercise: ______

# of Hours of Sleep on Average: ______ Temperament:______

Recreation: ______

Medications Taken Regularly:

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

COMMENTS

Any additional information that the doctor should be aware of, or any concerns that you wish to discuss:

______

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ADVENT INTERNAL MEDICINE

George G. Kim, M.D. and Jeremy Pettit, PA-C

Please use this page to list all of the doctors you have seen in the past three years, Including their names, and phone numbers.

1)

2)

3)

4)

5)

6)

7)

8)

9)

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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