Willis Knighton Health

WILLIS KNIGHTON GENETICS CLINIC

2600 Kings Hwy, Ste 200A, Shreveport, LA, 71103 • Office: 318-212-6258 • FAX: 318-212-6249

PERSONAL AND FAMILY HISTORY QUESTIONNAIRE

INSTRUCTIONS: Please complete this form to the best of your ability **PRIOR** to your appointment. Please remember to list **ALL** relatives, living and deceased, regardless of if they have been affected by the concern in question. If you are unsure about a family member's health history, please try to discuss this with a relative **PRIOR** to the appointment. Bring any **COPIES** of genetic testing results to the appointment if testing has been completed for your family member or yourself in the past.

DEMOGRAPHIC INFORMATION:

Name:	Email
Date of Birth:	Alternate Phone #:
Address:	City:
State:	Zip:
Home Phone:	Occupation:
Cell Phone:	Secondary Contact Name:
Gender: ☐ Female ☐ Male	Secondary Contact Phone #:
Referring Provider:	Specialist (if applicable):
Primary Care Provider (if different from above):	Specialist (if applicable):
Oncologist (if applicable):	Specialist (if applicable):

Mother's family ancestry (i.e. French, German, Irish):

Father's family ancestry (i.e. English, Italian, Dutch):

PLEASE BRING THIS COMPLETED PACKET TO YOUR APPOINTMENT:

DATE:_____ **TIME:**_____ **OFFICE:**_____

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Do you have any Jewish or Ashkenazi Jewish ancestry in the family (circle one): Yes No

If so what side of the family: Maternal Paternal

PERSONAL HEALTH HISTORY:

1. **Have you ever had cancer (circle one)?** Yes No If the answer is No, SKIP to question #2.

Type of cancer:	Age at diagnosis:
Type of cancer:	Age at diagnosis:

2. **Date of Last Colonoscopy:**_____
3. **Have you ever had any colon polyps?** Yes No Age at first colon polyp: _____
   Total number and type of polyps in your lifetime:_____
4. **Have you ever Smoked?**_____ If yes, # packs per day:_____ # Years smoked:_____
   What age did you start smoking:_____ If you have quit, what age did you stop smoking: _____
5. **Do you drink alcohol regularly?** Yes / No. If yes, # beverages per day:_____
   # Years: _____ . Beverage of choice:_____

FOR WOMEN ONLY:

- What age did you start your first period: _____ What age did your periods stop: _____
  Circle Reason: Surgical Menopause Cancer Treatment Natural Menopause
- # of Pregnancies:_____ # of Live Births:_____ # of Miscarriage/Abortions:_____
  How old were you with your first birth:_____ Did you breast feed 1 month or longer: yes no
- History of abnormal pap smear: Yes No Age:_____Date of Last Pap Smear:_____
- Have you ever taken Hormone Replacement Therapy:_____ If so, years taken:_____
  Type of HRT (circle one): Estrogen Progesterone Both Taken continuously: yes no
- Have you ever taken Oral contraception: _____ If so, # of years taken:_____
  Age Started: _____ Age Stopped:_____ Taken continuously: yes no
- Have you ever taken Fertility treatments: _____ If so, # of years taken:_____
- Have you ever had a breast biopsy: _____ How many in your lifetime:_____

If outside the WK system, **where**, at what **age**, and what did the **pathology** show: _____

_____

- Have you ever been told you have dense breast tissue? _____ Last Mammogram: _____
- Have you ever had a hysterectomy (uterus removed): _____ What age:_____
- Have you ever had an oophorectomy (ovaries removed):_____ What age: _____
  Reason: _____

Circle One: Both Ovaries Removed Right Ovary Removed Left Ovary Removed

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WILLIS KNIGHTON GENETICS PROGRAM

FAMILY HEALTH HISTORY continued

YOUR CHILDREN: (please list all, even those without health concerns)

First Name:	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

YOUR GRANDCHILDREN: (please list all, even those without health concerns)

First Name:	Parent Name:	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				

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WILLIS KNIGHTON GENETICS PROGRAM
FAMILY HEALTH HISTORY continued

YOUR BROTHERS AND SISTERS: (please list all, even those without health concerns)

First Name:	If Sibling is half Sibling, what side?	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
	☐ Full ☐ Same Mother ☐ Same Father	M / F				
	☐ Full ☐ Same Mother ☐ Same Father	M / F				
	☐ Full ☐ Same Mother ☐ Same Father	M / F				
	☐ Full ☐ Same Mother ☐ Same Father	M / F				
	☐ Full ☐ Same Mother ☐ Same Father	M / F				
	☐ Full ☐ Same Mother ☐ Same Father	M / F				

YOUR NEPHEWS AND NIECES: (please list all, even those without health concerns)

First Name:	Parent Name:	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				

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FAMILY HEALTH HISTORY continued

YOUR FATHER AND PATERNAL GRANDPARENTS: (please list all, even any without health concerns)

Relative:	First Name:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
Father					
Your Father's Father					
Your Father's Mother					

YOUR AUNTS AND UNCLES ON FATHER'S SIDE: (please list all, even any without health concerns)

First Name:	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

1st COUSINS ON FATHER'S SIDE (please list all, even those without health concerns)

First Name:	Parent Name:	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				

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WILLIS KNIGHTON GENETICS PROGRAM
FAMILY HEALTH HISTORY continued

YOUR MOTHER AND MATERNAL GRANDPARENTS: (please list all, even any without health concerns)

Relative:	First Name:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
Mother					
Your Mother's Father					
Your Mother's Mother					

YOUR AUNTS AND UNCLES ON MOTHER'S SIDE: (please list all, even any without health concerns)

First Name:	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

1st COUSINS ON MOTHER'S SIDE (please list all, even those without health concerns)

First Name:	Parent Name:	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:	Age at Diagnosis:
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				

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Informed Consent for Genetic Testing

I, _____ , authorize WK Genetics to conduct genetic testing as ordered by my genetic provider and authorize the collection of the sample for the purposes of genetic testing. I acknowledge and consent to the following as fully covered by my genetic provider:

- Purpose, description, and nature of the test and its potential uses;
- Potential results: positive, carrier, negative, and/or variant of uncertain significance;
- Reliability of the results, and the implications of doing genetic tests including medical risk, limitations, and benefits;
- Description of the disease or condition tested for and testing serves as a predictor of disease and may or may not impact my medical management and screening options;
- Positive test results indicate I may be predisposed to or have a specific disease or condition and that additional testing including imaging, blood tests, or other tests may be necessary to confirm or monitor for a disease or condition;
- Negative or variant of uncertain significance test results indicates that the clinically significant variant tested for was not detected but based on personal and family history I may still be at risk for a particular disease or condition;
- I will receive the test results from WK Genetics and that I have a right to confidential treatment of my sample and results. My results will only be disclosed as authorized in this consent and to my healthcare providers;
- Genetic testing of appropriate individuals is typically reimbursed by health insurance or covered by HMOs, but I may be responsible for any costs of the genetic testing not reimbursed by insurance
- I have been given the opportunity to ask questions, and understand I have the right to ask any other questions at any time. I voluntarily agree to genetic testing;

I authorized my test results to be disclosed the following person(s):_____

_____

Signature of Patient/Parent/Legal Guardian/Representative Date/Time

_____

Printed Name of Patient/ Parent/Legal Guardian/Representative If indicated, relationship to patient

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Willis Knighton Health

ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind. I hereby authorize the hospital to release all test results to my insurer(s).

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis Knighton Health (WKH) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness''). Debtor acknowledges and agrees that, unless waived in full by WKH as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKH may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKH, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKH, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKH in determining the amounts due as set forth hereinabove. I understand and agree that WKH will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKH and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKH as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment. WKH agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKH all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKH the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKH to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKH in connection with the procurement of any information or documents WKH deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKH under the terms of this assignment. Any receipts from WKH shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKH receives proceeds and/or payments in excess of the Indebtedness, WKH may apply such excess payment to any outstanding Indebtedness of Debtor to WKH arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date:

Admission Time:

Willis Knighton Health
2600 Greenwood Road
Shreveport, LA 71103

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Patient _____ Previous Names, if applicable _____

Date of Birth _____ Daytime Telephone Number _____

SEND INFORMATION TO: (please be specific)
Provider Name/Organization: _____
Address: _____

Phone #: _____ Fax #: _____

INFORMATION TO BE RELEASED FROM: (please be specific)
Provider Name/Organization: _____
Address: _____

Phone #: _____ Fax #: _____

PURPOSE OF DISCLOSURE: ☐ Transfer of Care ☐ Self ☐ Specialist ☐ Other _____ (must complete)

INFORMATION TO BE DISCLOSED:
- ☐ Medical Records from last two years
- ☐ Summary Health Information
- ☐ Complete Designated Record Set
- ☐ Other: _____

☐ Paper Copy ☐ Electronic Copy (CD-ROM)

Dates of Service: _____

Expiration Date (or event) _____

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPAA of 1996. I acknowledge that I have received a copy of the Notice of Privacy practices. _____ (Initials)

Date/Time _____ Signature of Patient or Representative _____ Relationship to Patient _____

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

- ☐ HIV/AIDS Virus _____
- ☐ Mental Health/Psychiatric Disorders _____
- ☐ Sexually Transmitted Diseases _____
- ☐ Drug, Alcohol Abuse/Treatment _____

Date/Time _____ Signature of Patient or Representative _____ Relationship to Patient _____

For Facility Use:
Date Received: _____ Date Information Released: _____ Chart #: _____
Person /Department Sending Records: _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + ____ + ____ + ____

= Total Score: ____

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
☐	☐	☐	☐

Patient Signature

Printed Name Date/Time

Staff Signature

Printed Name Date/Time

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9) continued

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