San Clemente MEDI-CENTER
910 S. El Camino Real, Suite A; San Clemente, CA 92672
Tel. (949) 492-4994 | Fax (949) 492-4995
www.scmedicenter.com

Thank you for choosing San Clemente Medi-Center for your health needs. In order to serve you properly, the following information is needed. All information will remain confidential. Please fill out all sections that apply to you.

Registration Form - Patient Information

Name: _____
First **Middle** **Last**

Sex: ◯M/ ◯F **Date of Birth:** ____/____/____ **Marital Status:** ◯S/ ◯M/ ◯D/ ◯W/ ◯SEP/ ◯DP

US Federal Government Requirement

Ethnicity: ◯Hispanic / ◯Non-Hispanic / ◯Decline, **Race:** _____ **Preferred Language:** _____

Whom may we thank for referring you: _____

Contact Information

Phone: Main#: _____ **Cell#:** _____ **Work#:** _____

Email Address: _____

Home Address: _____
Street address City State Zip

Mailing Address: _____
(if different) Street address City State Zip

Work Address: _____
Street address City State Zip

Emergency Contact(s)

(1) Name: _____ **Relationship:**_____ **Phone#:** _____

(2) Name: _____ **Relationship:**_____ **Phone#:** _____

Insurance

Do you have any Medical Insurance? ◯Yes/ ◯No. **If Yes, is it an HMO Plan?** ◯Yes/ ◯No _____

Insurance Company: _____ **Name of Primary Care Physician:** _____

Please carefully read and sign important office policy forms and financial agreement on the following pages.

I have read and signed the Arbitration Agreement Form, HIPAA Compliance Form and Financial Agreement Form (included in packet):

☐ I would also like to be offered an Integrative/Complementary Medicine approach whenever possible to possibly shorten or eliminate need for more medications. I will request more information from the physician if needed. I know that this is an added alternate healing option available to me.

☐ I would like to decline any other form of therapy other than the Traditional / Allopathic Medicine.

X_____ _____/_____/_____
Signature of Patient or Parent / Guardian if Minor **Date**

Physician-Patient Arbitration Agreement for San Clemente Medi-Center

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counseling fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nor supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services: X_____ PLEASE SIGN (Patient or Representative's Signature)

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____ By: **X** _____ _____/_____/_____

Physician's or Authorized Representative's Signature **Date** **Patient or Representative's Signature** **Date**

SAN CLEMENTE MEDI CENTER
910 S. El Camino Real, Suite 100, San Clemente, CA 92672
Tel: (949) 492 4994 Fax: (949) 492 4995

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document will be given to the Patient upon request. Original is to be filed in Patient's medical records.

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SCMC HIPAA Compliance Form and Financial Agreement

In order to control the cost of billings, we request that your portion of charges incurred be paid at the time service is rendered, unless prior arrangements have been made.

Please remember that insurance is a method for reimbursing the patient for fees paid to the doctor and is not a substitute for payment; all professional services given are charged to, and are the responsibility of, the patient. As a courtesy to you, we file claims with pre-authorized insurance companies, and therefore it is your responsibility to provide us with insurance cards or other necessary information. It is also your responsibility to notify us of any changes in your insurance coverage and/or important contact information such as, but not limited to, your telephone number and address.

I hereby assign to and authorize payment of all benefits payable under the terms of my health insurance policy (policies) to my physician if payment in full is not made at the conclusion of my visit. I also understand that charges are assigned in full upon services rendered.

I also understand that I am financially responsible for all charges whether or not paid by health insurance policy (policies) within 30 days of receipt of bill. In the event that this account becomes delinquent, I will be responsible for any unpaid balances, collection fees, and/or reasonable attorney's fees associated with collection of any unpaid balances for services provided.

I have been informed that San Clemente Medi-Center will, only after prior financial arrangements have been made, carry any unpaid balance for up to three months. All unpaid balances beyond three months will be turned over to a collection agency and are no longer maintained in the SCMC business office.

I authorize the release of any medical information necessary to process all claims. If there is an individual to whom I specifically wish or do not wish to authorize release of my medical records, I will notify the physician in writing.

San Clemente Medi-Center values your trust and does its best to protect your confidentiality. In return, we request that you disclose all symptoms, conditions, and medical history fully and accurately to receive the best possible treatment.

May we: (Mandatory to fill out)	**Yes**	**No**	**Comments (If Any)**
Leave Confidential Messages on your telephone voicemail or answering machine?	○	○	
Mail correspondence from our office in a sealed envelope marked "CONFIDENTIAL"?	○	○	
Inform anyone other than Emergency Contact(s) about your medical condition, diagnosis, treatment or payment?	○	○	

Please list any other instructions: _____

_____

_____

I hereby authorize and consent to examination and treatment at San Clemente Medi-Center:

X _____
Parent/Guardian Signature *(if under age 18)*

X _____
Patient Signature

X _____
Print Parent/Guardian Name

X _____
Print Patient Name

Date: _____/_____/_____

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NOTICE OF PRIVACY PRACTICES-(HIPAA)

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USEDAND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice tells you about the ways San Clemente Medi-Center, may collect, store, use and disclose your protected health information and your rights concerning your protected health information. "Protected Health Information" is information about you that can be used to identify you and that relates to your past, present or future health condition, the provision of care to you or the payment for that care. Federal and state laws require us to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is still in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Uses and Disclosures of your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are illustrations of the different types of uses and disclosures that we may make without obtaining you authorization.

1. **Payment**. We may use and disclose your protected health information in order to obtain payment from your insurance carrier for your covered expenses.
2. **Treatment**. We may use and disclose your protected health information to assist in your diagnosis and treatment referral to specialist, laboratories, etc.
3. **Health Care Operations**. We May use and disclose your protected health information in order to assist your insurance carrier(s) in plan activities, such as their quality assessment activities, or administrative activities, including data management or customer service.

Other Permitted or Required Disclosures

1. **As Required by Law.** We must disclose protected health information about you when required to do so by law.
2. **Public Health Activities.** We may disclose your protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
3. **Victims of Abuse, Neglect or Domestic** Violence. We may disclose your protected health information to government agencies about abuse, neglect or domestic violence.
4. **Judicial and Administrative Proceeding**. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
5. **Law Enforcement**. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
6. **Coroners or Funeral Directors.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties.
7. **To Avert a Serious Threat to Health or Safety**. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
8. **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
9. **Workers' Compensation**. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses or Disclosures with an Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed.

1. **Your Rights Regarding your Protected Health Information**. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include billing, claims payment and case or medical management records. Your request to review and /or obtain a copy of your protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
2. **Right to Amend Your Protected Health/ Information**. If you feel that your protected health information maintained by San Clemente Medi-Center incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, if for example, you ask to amend information that was not created by San Clemente Medi-Center, or you ask us to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you immediately. You have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
3. **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures we have

made of your protected health information, excluding disclosures for payment, health care operations, your authorized disclosures, or national security purposes. Your request for an accounting of disclosures must be in writing and must state a time period for which you want an accounting. This time period may not be longer than 6 years and may not include dates before April 14, 2014. Your request should indicate in what form you want the list (paper or electronically). For additional lists with in the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

4. **Right to Request Restrictions on the Disclosure of Your Protected health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. ***We may not agree to your request.*** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
5. **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
6. **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
7. **Contact Information *for* exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Offer. See the end of this notice for contact information.

Health Information security

San Clemente Medi-Center requires its employees to follow its security policies and procedures that limit access to your health information to those employees who need it to perform their job responsibilities. In addition, San Clemente Medi-Center maintains physical, administrative and technical security measures to safeguard your protected health/ information.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any other information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may file a complaint with us by contacting the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. We support your rights to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Disclaimer

If you are a Medi-Cal beneficiary, the law may not allow some of the disclosures listed above. Medi-Cal limits the use of information about you to purposes directly connected to the operations of the Medi-Cal program.

Privacy Officer

For questions/complaints, please contact SCMC Office Manager: Tel. (949) 492-4994 or Fax (949) 492-4995

You may also contact The Department of Health Services at: Privacy Officer, California Department of Health Services, P.O. Box 942732, Sacramento, CA 94234- 7320, (866) 255-5259 or (877)735-2929 TTY/TDD or you may contact the U.S. Department of health and Human Services, Office for Civil Rights, Attention: Regional Manage, 50 United Nations Plaza Room 332, San Francisco, CA 94 l02. For additional information, call (800)368-1019 or U. S. Office For Civil Rights at (866) OCR-PRIV (866-627-7748) or (866) 788-4989 TTY.

X _____ _____/_____/_____

Print Patient Name **Patient Signature** **Date**

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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ **Date of Birth:** ____/____/_____

Introduction:

Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Anticipated Benefits:

- Improved access to medical care by enabling a patient to remain in his/her location while the physician may provide care from a distant site.
- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician;
- Delays in medical evaluation/treatment could occur due to deficiencies or failures of the electronic equipment;
- In rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to all of your medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Please sign here after reading this page X_____

Informed Consent for Telemedicine

By Signing this Form, I Understand the Following:

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that the laws that protect the privacy and security of health information apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my authorization.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time.
4. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My physician has explained the alternative to my satisfaction.
6. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
7. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have with other healthcare providers.
8. I understand that if my medical insurance coverage (except for government health programs) is not sufficient to satisfy the medical service charges in full, I will be fully responsible for payment.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Dr. Darshana Kadakia or Dr. Rajesh Kadakia or other physicians / clinicians / students working with Dr. Kadakia to use telemedicine program in the course of my diagnosis and treatment.

X_____ _____/_____/_____

Signature of Patient ***Date***

(or person authorized to sign for the patient)

If authorized signer, specify relationship to patient: _____

Witness: _____X_____ ***Date:*** _____/_____/_____

(Name & Signature)

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DETAILED MEDICAL HISTORY

NAME: _____ **DATE:** ____/____/_____
First *Middle* *Last*

AGE: _____ **SEX:** ◯M / ◯F **HEIGHT:** _____' _____" **WEIGHT**: _____ lbs. **OCCUPATION:** _____

MARITAL STATUS: ◯**S/** ◯**M/** ◯**D/** ◯**W/** ◯**SEP/** ◯**DP**

Reason for the visit and duration of symptoms:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

<u>Are you Allergic</u> to any Medications? ◯**Yes/** ◯**No** (Circle), **to food or environments?** ◯**Yes/** ◯**No** (Circle)

Medication	Reaction / Intolerance	Food or Environment	Reaction / Intolerance
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____

Please list all the Medications, Vitamins, Supplements, etc. (Prescription and Over the counter) **that you have been taking currently:**

Medication Name	Strength / mg	Frequency/day	Reason taking	Duration

PAST MEDICAL HISTORY PAGE 2

NAME:_____
First Middle Last

Please mark 'x' only if you have any of the following condition(s) that you have been diagnosed with and/or treated for.

CARDIOVASCULAR- ◯Yes/◯No	**GASTROINTESTINAL-◯Yes/◯No**	**ENDOCRINE-◯Yes/◯No**	**MUSCULOSKELETAL-◯Y/◯No**
☐ Angina/Chest Pain	☐ Colon Cancer	☐ Addison's Disease	☐ Back Problems/ Back Injury
☐ Angioplasty & Stent Placement	☐ Crohn's Disease	☐ Cushing's Disease	☐ Carpal Tunnel Syndrome
☐ Arrhythmias/ Dysrhythmias	☐ Diverticulitis/Diverticulosis	☐ Diabetes Mellitus- Adult Onset	☐ Degenerative Disk Disease
☐ Arterial Thrombosis	☐ Gall Stones	☐ Diabetes Mellitus- Juvenile	☐ Degenerative Joint Disease
☐ Atrial Fibrillation	☐ Gastrointestinal Bleed	☐ Epilepsy/ Seizures,	☐ Fibromyalgia
☐ Cardiac Catheterization	☐ GERD/Gastro esophageal Reflux	☐ Hyperaldosteronism	☐ Foot Problems
☐ Cardiomyopathy	☐ H. Pylori Infection	☐ Hyperthyroidism	☐ Fractures
☐ Congestive Heart Failure	☐ Hemorrhoids	☐ Hypothyroidism	☐ Gout
☐ Deep Venous Thrombosis	☐ Hepatitis-☐A ☐B ☐C	☐ Metabolic Syndrome	☐ Muscle Disease
☐ Heart Attack	☐ Hiatal Hernia	☐ Thyroid Cancer	☐ Osteoarthritis
☐ Heart Murmur	☐ Irritable Bowel Syndrome	☐ Thyroid Disorder	☐ Osteoporosis/Osteopenia
☐ High Cholesterol	☐ Jaundice	**NEUROLOGIC- ◯Yes/ ◯No**	☐ Polymyalgia Rheumatica
☐ High Triglycerides	☐ Liver Disease	☐ Alzheimer's Dementia	☐ Rheumatoid Arthritis
☐ Low HDL	☐ Other GI Cancer	☐ Chorea	☐ Sciatica
☐ Hypertension / High BP	☐ Pancreatitis	☐ Headaches	☐ Sjogren's Disease
☐ Mitral valve prolapse	☐ Peptic Ulcer Disease	☐ Mental Retardation	☐ Systemic Lupus Disorder
☐ Peripheral Vascular Disease	☐ Rectal Fistula	☐ Migraine	☐
☐	☐ Ulcerative Colitis	☐ Multiple Sclerosis	**OTHER- ◯Yes/ ◯No**
☐	☐	☐ Neuropathy	☐ Attempt to quit addiction
RESPIRATORY- ◯Yes/ ◯No	**GENITOURINARY- ◯Yes/ ◯No**	☐ Parkinson's Disease	☐ Blood Disease
☐ Allergic Sinusitis/Rhinitis	☐ Atrophic Vaginitis	☐ Pituitary Disorder	☐ Blood Transfusion
☐ Asthma	☐ Benign Prostatic Hypertrophy	☐ Senile /Other Dementia	☐ Cataracts
☐ Bronchiectasis	☐ Chronic Renal Failure	☐ Stroke/Paralysis/TIA	☐ Counseling to quit addiction
☐ Bronchitis - Recurrent	☐ Endometriosis	☐ Tremors	☐ Dengue Fever
☐ COPD / Chronic Bronchitis	☐ Hematuria	**PSYCHIATRIC- ◯Yes/ ◯No**	☐ Exposure to HIV/Hepatitis
☐ Emphysema	☐ Hemodialysis	☐ ADHD/ADD	☐ Glaucoma
☐ Hay Fever	☐ Menstrual Disorders	☐ Alcoholism- ◯current / ◯past	☐ HIV Related Diseases
☐ Lung Cancer	☐ Ovarian Cancer	☐ Anorexia/ Bulimia	☐ Leukemia
☐ Pneumonia	☐ Pelvic Inflammatory Disease	☐ Anxiety	☐ Malaria
☐ Pneumothorax	☐ Prostate Cancer	☐ Bipolar Depression	☐ Multiple Myeloma
☐ Positive PPD	☐ Prostatitis	☐ Depression	☐ Obesity
☐ Pulmonary Embolism	☐ Pyelonephritis	☐ Drug Addiction-◯current/ ◯past	☐ Other Skin Disorders
☐ Pulmonary Fibrosis	☐ Renal Stones	☐ Drug Overdose	☐ Other Tumors
☐ Silicosis/Asbestosis	☐ Uterine Fibroid	☐ Other Mental Illness	☐ Retinal Detachment
☐ Sleep Apnea	☐ Venereal Disease/STD	☐ Psychosis/ Neurosis	☐ Tropical Disease
☐ Tuberculosis	☐ Recurrent Urinary Tract Infections	☐ Rehab for _____	☐ Work related injury
☐	☐	☐ Suicide Attempt	☐ Multiple Myeloma

PAST SURGICAL HISTORY: ◯None / ◯Yes (Circle)

Please **mark 'X' if yes** and add any other **condition(s)** that you have been treated for and the year of treatment.

Operation/ Trauma/ Procedure	**Year**	**Operation/ Trauma/ Procedure**	**Year**
☐ Appendectomy		☐ Ovarian Cyst Removal	
☐ Back surgery – neck / low back		☐ Pacemaker/Defibrillator Placement	
☐ Breast Surgery		☐ Prostatectomy	
☐ Cholecystectomy		☐ Tonsillectomy & Adenoidectomy	
☐ Coronary Artery Bypass Graft		☐ Transurethral Resection Of Prostate	
☐ Cosmetic Surgery		☐ Vasectomy	
☐ Dilation And Curettage		**Fractures: List Site**	
☐ Gastric Stapling		☐	
☐ Hernia Repair		☐	
☐ Hysterectomy Total/Partial		☐	
☐ Open Reduction & Internal Fixation		☐	

PERSONAL HISTORY

NAME: _____
First *Middle* *Last*

Please describe your current or past history of tobacco, alcohol and substance abuse and caffeine use.

				Amount	How Long?	Would you like to Quit?	
Substances	**Current**	**Past**	**Never**	Per Day / Week	Month / Years	**Yes**	**No**
Smoking	☐	☐	☐			☐	☐
-Passive/ Second-hand	☐	☐	☐			☐	☐
-Cigarettes: *Packs/day*	☐	☐	☐			☐	☐
-Cigars	☐	☐	☐			☐	☐
-E-Cigarette	☐	☐	☐			☐	☐
Tobacco Chewing	☐	☐	☐			☐	☐
Nicotine Use	☐	☐	☐			☐	☐
Caffeinated Beverages	☐	☐	☐			☐	☐
Drinking	☐	☐	☐			☐	☐
-Beer	☐	☐	☐			☐	☐
-Wine	☐	☐	☐			☐	☐
-Hard Liquors	☐	☐	☐			☐	☐
Illicit Drugs – specify:	☐	☐	☐			☐	☐
-Marijuana	☐	☐	☐			☐	☐
-Cocaine	☐	☐	☐			☐	☐
-Meth/Amphetamine	☐	☐	☐			☐	☐
-PCP	☐	☐	☐			☐	☐
-Opiates	☐	☐	☐			☐	☐
-IV	☐	☐	☐			☐	☐

EDUCATION: ○ No High School / ○ High School / ○ Undergraduate / ○ Graduate / ○ _____

OCCUPATION: _____ **HOBBIES:** _____

FAMILY HISTORY

Please mark 'x' if any of your family members have had any of the following or other medical conditions:

☐AIDS/HIV Infection	☐Bleeding/Clotting Disorders	☐Diabetes	☐High Blood Pressure	☐Lung Disease	☐Seizures
☐Allergies	☐Cancer	☐Dementia	☐Hyperlipidemia	☐Mental Disorder	☐Stroke
☐Alcoholism	☐Collagen Vascular Disorder	☐Heart Attack	☐Kidney Disease	☐Neurology Disorder	☐Thyroid Disease
☐Asthma	☐COPD	☐Hepatitis B / C	☐Liver Disease	☐Rheumatoid Arthritis	☐Tuberculosis
☐Other:					

Relation	Age (if living)	Medical Condition	Deceased	Cause of Death & Age	Comments

NAME: _____
First *Middle* *Last*

Have you been in good general health most of your life? ◯**Yes /** ◯**No** *(please circle)*

Please mark <u>only</u> if you have any of the following conditions:

GENERAL	Current	Recurrent	None	Other
1. Fatigue	☐	☐	☐	
2. Weight loss___/gain__	☐	☐	☐	
3. Fever? up to _____°F	☐	☐	☐	
4. Chills	☐	☐	☐	
5. Night Sweats	☐	☐	☐	
6. Other	☐	☐	☐	
EENT				
1. Refractory error	☐	☐	☐	
2. Loss/Blurred Vision	☐	☐	☐	
3. Ear Disease	☐	☐	☐	
4. Hearing loss	☐	☐	☐	
5. Use hearing aid	☐	☐	☐	
6. Nasal Polyps	☐	☐	☐	
7. Nose Bleeds	☐	☐	☐	
8. Rhinitis/postnasal drip	☐	☐	☐	
9. Sinusitis	☐	☐	☐	
10. Sore Throat	☐	☐	☐	
11. Hoarseness of voice	☐	☐	☐	
12. Tooth & gum trouble	☐	☐	☐	
13. Other	☐	☐	☐	
CHEST				
1. Chest Pain	☐	☐	☐	
2. Angina	☐	☐	☐	
3. Pleurisy	☐	☐	☐	
4. Palpitations	☐	☐	☐	
5. Swelling of ankles/feet	☐	☐	☐	
6. Difficulty Breathing	☐	☐	☐	
-with exertion/ at night	☐	☐	☐	
7. Cough	☐	☐	☐	
8. Sputum production	☐	☐	☐	
Sputum Color _____	☐	☐	☐	
9. Blood in sputum	☐	☐	☐	
10. Wheezing	☐	☐	☐	
11. Excessive Snoring	☐	☐	☐	
12. Stop Breathing during sleep	☐	☐	☐	
13. Daytime sleepiness	☐	☐	☐	
14. Other	☐	☐	☐	
GASTROINTESTINAL				
1. Loss of appetite	☐	☐	☐	
2. Difficulty swallowing	☐	☐	☐	
3. Heart burn	☐	☐	☐	
4. Indigestion	☐	☐	☐	
5. Nausea	☐	☐	☐	
6. Vomiting	☐	☐	☐	
7. Diarrhea	☐	☐	☐	
8. Constipation	☐	☐	☐	
9. Dark Stool	☐	☐	☐	
10. Blood in Stool	☐	☐	☐	
11. Hemorrhoids	☐	☐	☐	
12. Abdominal pain	☐	☐	☐	
13. Hepatitis	☐	☐	☐	
14. Gall stones	☐	☐	☐	
15. Other	☐	☐	☐	

NEUROLOGY & PSYCHIATRY	Current	Recurrent	None	Other
1. Headaches	☐	☐	☐	
2. Dizziness	☐	☐	☐	
3. Numbness/tingling	☐	☐	☐	
4. Paralysis	☐	☐	☐	
5. Fainting episodes	☐	☐	☐	
6. Seizures --Type_____	☐	☐	☐	
7. Anxiety/ Excessive worrying/Panic Attacks	☐	☐	☐	
8. Depression-◯Mild/◯Moderate/◯Severe	☐	☐	☐	
9. Other	☐	☐	☐	
ENDOCRINE				
1. Excessive urination	☐	☐	☐	
2. Excessive thirst	☐	☐	☐	
3. Unusual Intolerance to heat	☐	☐	☐	
4. Unusual Intolerance to cold	☐	☐	☐	
5. Other	☐	☐	☐	
HEMATOLOGY				
1. Anemia	☐	☐	☐	
2. Bruise easily	☐	☐	☐	
3. Prolonged bleeding	☐	☐	☐	
4. Other	☐	☐	☐	
MUSCULOSKELETAL				
1. Stiff/painful/Swollen joints	☐	☐	☐	
2. Back aches	☐	☐	☐	
3. Gout	☐	☐	☐	
4. Other	☐	☐	☐	
GENITOURINARY				
1. Frequent Urination	☐	☐	☐	
2. Blood in urine	☐	☐	☐	
3. Painful urination	☐	☐	☐	
4. Night time urination	☐	☐	☐	
5. Other	☐	☐	☐	
MALE (For Males Only)				
1. Venereal Disease & Type _____	☐	☐	☐	
2. Hernia	☐	☐	☐	
3. Testicular pain	☐	☐	☐	
4. Testicular swelling	☐	☐	☐	
5. Impotence	☐	☐	☐	
6. Other	☐	☐	☐	
FEMALE (For Females Only)				
1. **Date of Last menstrual cycle**	/ /			
2. ☐Peri-Menopause / ☐Post menopause / ☐Hysterectomy Partial / ☐Total				
3. Abnormal /absence of menses	☐	☐	☐	
4. Number of pregnancies	☐	☐	☐	
5. Number of live births	☐	☐	☐	
6. Number of Miscarriages/Abortions	☐	☐	☐	
7. Birth control pills	☐	☐	☐	
8. Breast Lump	☐	☐	☐	
9. Nipple Discharge	☐	☐	☐	
10. **Last Mammogram**	☐	☐	☐	
Findings: ◯Normal / ◯Abnormal				
11. **Last pap smear** ◯Normal/ ◯Abnormal	☐	☐	☐	
12. Venereal disease: Type_____	☐	☐	☐	
13. Homo/Bisexuality	☐	☐	☐	