

Health Questionnaire

Name _____ Age _____ Today's Date _____ Ht _____ Wt _____

Reason for Visit: _____

Past Medical History/ Type of Medical Problems: _____

Past Surgeries/ Last colonoscopy and results _____

Last pap smear (month/year) and results: _____ Hysterectomy No Yes

Last mammogram (month/year) and results: _____ Last Menstrual Cycle: _____

Lat Tetanus Vaccine _____ **Last Pneumonia Vaccine** _____ **Last Flu Vaccine** _____

Family History: Any family members have any of the following

Cancers	No	Yes	Who	Type of Cancer
Strokes	No	Yes	Who	_____
Heart trouble	No	Yes	Who	_____
High blood pressure	No	Yes	Who	_____
Diabetes	No	Yes	Who	_____
Mental Illness	No	Yes	Who	_____

Social History

Any Drug Use	No	Yes	Type	_____
Any Alcohol Use	No	Yes	How often	_____
Single	Married	Separated	Divorced	Widowed
Children	No	Yes	How many	_____
Employed	No	Yes	Type of work	_____
Smoking	No	Yes	Frequency	_____

Allergies to medications

Medications Please list on back side of paper

Review of System

General			Genitourinary		
Fever	No	Yes	Loss of urine	No	Yes
Chills	No	Yes	Frequent urination	No	Yes
Unexpected weight loss	No	Yes	Burning/pain in urination	No	Yes
			Blood in urine	No	Yes

Head/Neck/Eyes/Ear Nose/Mouth/Throat

Loss of Consciousness	No	Yes	Musculoskeletal/Skin/Breast		
Dizziness	No	Yes	Weakness of muscle/joints	No	Yes
Sudden vision change	No	Yes	Difficulty walking	No	Yes
Neck stiffness	No	Yes	Rash	No	Yes
Enlarged glands	No	Yes	Skin disease	No	Yes
Itchy Eyes	No	Yes	Abnormal skin pigmentation	No	Yes
Recent Eye Injury	No	Yes	New breast lumps	No	Yes
Ear Pain	No	Yes	Breast pain	No	Yes
Ear Drainage	No	Yes	Nipple Drainage	No	Yes
Hearing Loss	No	Yes			
Nose bleeds	No	Yes	Neurological/Psychological		
Runny nose	No	Yes	Seizures	No	Yes
Mouth lesions	No	Yes	Paralysis	No	Yes
Mouth Pain	No	Yes	Suicidal thoughts	No	Yes
Throat pain	No	Yes	Thoughts of hurting others	No	Yes

Heart/Lung

Heart/Lung			Endocrine/ Hematologic/Lymphatic		
Chest Pain	No	Yes	Change in hair growth	No	Yes
Shortness of breath	No	Yes	Feeling more hot/cold	No	Yes
Hand/feet/ankle swelling	No	Yes	Skin becoming more dry	No	Yes
Coughing	No	Yes	Blood disease	No	Yes
Wheezing	No	Yes	Abnormal bleeding	No	Yes
Difficulty breathing	No	Yes			

Gastrointestinal

Vomiting	No	Yes	Blood in stool	No	Yes
Change in bowel habits	No	Yes	Abdomen pain	No	Yes
Diarrhea	No	Yes			

Patient Last Name: _____ First Name: _____ M.I.: _____ D.O.B.: _____

Home Address: _____ Birth Place: _____

Mailing Address: () Same as home _____

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Insurance Co. Name: _____ Policy #: _____ Subscriber Name: _____ Relationship to patient: _____

Secondary Insurance Co. Name: _____ Policy #: _____ Subscriber Name: _____ Relationship to pt: _____

Social Security #: _____ Marital Status: _____ Occupation: _____ Tobacco use: Yes No Former Never

Sex: M F () Choose not to disclose. Sexual Orientation: _____ () choose not to disclose. Language: _____

Race: () White () African American () Native Am. () Asian () Native Hawaiian/Pac. Islander () Decline to state Ethnicity: () Hispanic/Latino () Not Hispanic/Latino () Decline

Emergency Contact Name #1: _____ Phone (Home/Cell): _____ Relationship: _____

Emergency Contact #2: _____ Phone(Home/Cell): _____ Relationship: _____

Medicare Patient: I request that payment of authorized benefits be made either to me or on my behalf to KARIN C LI, MD, A PROF MEDICAL CORP for any services rendered to me by the physician or his/her associate. I authorize any holders of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. A Copy of this Signature is as valid as the original.

Commercial Insurance Patient: I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor, or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Patient Authorization/Health Insurance Portability and Accountability Act (HIPAA)

● Please indicate where you want to receive calls or information about your appointments, labs, or other health care issues that would come directly from our physicians or staff.

Home Phone: _____ Cell Phone: _____ Email: _____

● Can confidential messages (e.g. appointments, labs, referrals, and medical results) be left on your home answering machine, cell phone voicemail or email? () Yes () No

● Please list the family members or other persons whom we can inform about your general medical condition and/or diagnoses.

Name(s)/Relationship(s) _____

The information on this authorization is applicable for 1 year from the date this form is signed and agreed upon by the patient. After the 1 year period, this information will be automatically effective for consecutive 1 year periods UNLESS patient informs us to change the information above.

Patient Acknowledgement of Healthcare Information Privacy

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. 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 that treatment directly and indirectly; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may cause this organization at any time at the address of record to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

Penalty Fees & Insurance Member Eligibility Waiver

These are the penalty fees: **\$50** for a missed office appointment, **\$150** for a missed procedure appointment, and **\$25** for a "bounced check". Verification of your insurance (e.g. HMO, PPO, EPO, POS, etc) coverage for health care benefits will be performed as a courtesy. However, in the event your coverage is NOT effective, you will be held responsible for all payments.

General Consent

I hereby consent and request diagnostic procedures (e.g. Xrays, blood tests, medical treatment) and treatment deemed advisable by the professional staff of this practice. I acknowledge that I have read this consent form and understand its contents. I have had an opportunity to discuss it, and any questions I had have been answered to my complete satisfaction.

By signing below, you certify that all preceding information is correct and true. Furthermore, you have read, understood and agreed to all of the preceding information.

Patient/Guardian Signature _____ Date _____

Relationship to patient _____