Health Questionnaire

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

Reason for Visit: _____

Office only:

BP_____ HR_____ Temp_____

Past Medical History/ Type of Medical Problems: _____

2nd BP_____ **HR**_____

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			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			

How did you hear about the clinic? Family/Friend Insurance Website/Agent Insurance Co Auto-Assign Internet Postcard Other

KARIN LI, MD, INC - PATIENT REGISTRATION (English) KCL #1-3 (Rev: 09/1/25)

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 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 _____

HIPAA COMMUNICATION AUTHORIZATION

Patient Name: _____
Date of Birth: _____
Authorized Family/Contacts
I authorize the following person(s) to receive information about my care:
Name: _____ **Relationship:** _____
Phone: _____
Name: _____ **Relationship:** _____
Phone: _____
Phone & Voicemail Permission
Phone Number(s) Office May Use:
1.
2.
3.
Please select one:
☐**YES** — I authorize the office to leave confidential messages on voicemail at the numbers listed above.
☐ **LIMITED** — The office may leave only:
Appointment information Call-back request Other: _____ ☐ ☐ ☐
☐ **NO** — Please do not leave voicemail messages containing health information.
Family/Representative Communication
I authorize the office to speak with the individuals listed above regarding:
Appointments Medical/Treatment Information Test/Lab Results ☐ ☐ ☐
Medications Billing/Insurance ☐ ☐ ☐**All of the above**
I understand that I may revoke or change this authorization in writing.
Patient Signature: _____
Date: _____
Representative Name (if applicable): _____
Relationship/Authority: _____

Consent to Use an AI Scribe During My Visit

Please read this form and ask any questions before signing. Your care will not change if you decline.
What we are asking: During your visit, your clinician would like to use an **AI scribe** — software that listens to the conversation between you and your clinician, creates a written transcript, and drafts the clinical note for your medical record.
How it works: Audio is captured only while the tool is turned on, and only during your appointment. The audio is converted to a transcript and used to draft an encounter note. Your clinician **reviews and edits every note** before it becomes part of your medical record. The AI does not make medical decisions. Your privacy is protected The recording and transcript are Protected Health Information under **HIPAA** and are safeguarded like the rest of your record. Audio is used to generate your note. Your information is **not sold** and is **not used to train AI models** without separate, explicit authorization. Your rights Consent is **voluntary**. You may decline and receive the same quality of care. You may **withdraw consent at any time**, including during the visit — just tell your clinician and the tool will be turned off. You may ask questions about the tool, the vendor, and how your information is stored at any time. **A note on recording laws.** Some states require every person in a conversation to agree before it is recorded. By signing below you are giving that consent for the purpose described above. You may revoke it at any time.
Your decision
☐ **I CONSENT** to the use of an AI scribe as described above.
☐ **I DECLINE.** Please do not use an AI scribe during my visit.
Patient name (print) _____
Date of birth_____
Patient signature _____
Date_____
Personal representative signature (if applicable) · Relationship to patient

This consent supplements, and does not replace, the practice's Notice of Privacy Practices and general consent to treatment.
Retain in accordance with applicable HIPAA documentation requirements (minimum 6 years)