Krunal J. Mehta M.D.
130 W. Route 66 Suite 214
Glendora, CA 91740

Today's Date_____

Name_____ Telephone ( )_____
Last First

Address_____
Number and street City state Zip Code

Male or Female Age_____ Date of Birth_____ Social Security#_____

Occupation_____ Name of Employer_____

_____ Tel.# Work ( )_____
Address City State Zip Code

Name of person to contact in case of emergency_____ Relationship_____

Telephone # ( )_____ Referred by:_____

Do you have medical insurance? Yes No Co-Pay $_____

INSURANCE AUTHORIZATION & ASSIGNMENT

I, undersign, authorize **Krunal Mehta, M.D.** to provide care and treatment and to release medical information that may be requested by insurance companies and others to whom I have authorized and hereby request payment from my Health Care Insurance all benefits accruing to me under my Surgical , Hospitalization, and Medical Plan. I understand that I am financially responsible to the Physician for all charges not covered by this agreement. Hereby certify that if I am not eligible or retro activated or terminated, I am responsible for all charges for the services rendered.

X Signed_____ Date_____

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FAMILY PRACTICE/INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

_____

Other concerns:

_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

	ALLERGY	REACTION
1.		
2.		
3.		

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins, NSAIDs and inhalers.

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

IMMUNIZATION HISTORY

- ☐ Chickenpox Date:_____
- ☐ Flu Shot Date:_____
- ☐ Gardasil/HPV Date:_____
- ☐ Hepatitis A Date:_____
- ☐ Hepatitis B Date:_____
- ☐ Meningococcus Date:_____

Immunizations and most recent date:

- ☐ MMR (*Measles, Mumps, Rubella)*
  Date:_____
- ☐ Pneumonia Date:_____
- ☐ Tdap (*Tetanus and pertussis)* Date:_____
- ☐ Tetanus Date:_____
- ☐ Zostavax (*Shingles)* Date:_____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal
Last Mammogram Date _____ ☐ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause:
_____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____

- ☐ Cesarean sections If yes, then number: _____
- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual paln
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake In the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active

Current sexual partner is ☐ Female ☐ Male
Do you use condoms? ☐ Yes ☐ No
Other Birth control method used:_____

- ☐ Interested in being screened for STD's

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PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

SURGERY **REASON** **YEAR**
HOSPITAL

1. _____
2. _____
3. _____
4. _____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS SUCH AS **DEPRESSION, CANCER, DIABETES, HEART DISEASE, OSTEOPOROSIS, STROKE**
Grandmother (maternal)	Y/N	____	_____
Grandfather (maternal)	Y/N	____	_____
Grandmother (paternal)	Y/N	____	_____
Grandfather (paternal)	Y/N	____	_____
Father	Y/N	____	_____
Mother	Y/N	____	_____
Brother/Sister	Y/N	____	_____
Brother/Sister	Y/N	____	_____
Other:_____	Y/N	____	_____

SOCIAL HISTORY

OCCUPATION_____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level ☐ None (No exercise) ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? _____

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco? ☐ Yes ☐ No

If not currently, did you ever use tobacco?
☐ Yes ☐ No
☐ Cigarettes - _____pks./day ☐ Chew - _____/day ☐ Cigars - _____/day
☐ # of years_____
Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
_____
_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest heaviness/ Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/ Hunger/Urination
- ☐ Difficulty getting pregnant

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam: _____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent colds/sinus infections
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control
- ☐ Erectile dysfunction

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands
- ☐ Anemia

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Fracture Type_____
- ☐ Fall or imbalance
- ☐ Use of assist device

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems
- ☐ History of addiction

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

Patient, Parent, or Guardian Signature:_____

Date:_____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing how my private information is used of disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: Initials: Reasons:

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Patient Name: _____ Date: _____

Date of Birth: _____ Phone Number: (___) _____

1. What is your preferred language?
   [ ] English [ ] Spanish [ ] Other [ ] Prefer Not To Answer

2. What is your ethnicity?
   [ ] Hispanic or Latino [ ] White/Caucasian
   [ ] Other [ ] Prefer not so answer

   Race: [ ] White [ ] American Indian or Alaskan [ ] Asian [ ] African American/Black
   [ ] Native Hawaiian/other [ ] Refuse to answer

3. Marital Status: [ ] Divorced [ ] Married [ ] Single [ ] Widow(er) [ ] Other

4. In regards to smoking, are you:
   [ ] Current every day smoker
   [ ] Current some day smoker
   [ ] Former smoker
   [ ] Never smoker
   [ ] Smoker, Current Status Unknown
   [ ] Unknown if ever smoked

5. Alcohol History
   [ ] Never drink
   [ ] Currently drink
   [ ] Quit this year

6. Do you have any allergies? Example- medications, food, environment, cats, etc.
   [ ] No [ ] Yes-please list them here with type of reaction [ ] Prefer not to answer

_____

_____

_____

_____

_____ _____

Signature Date