

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

The purpose of this questionnaire is to gather information concerning your health and physical condition, both now and in the past. **This information is confidential.** Please answer all the following questions fully and completely as best as you can. If you don't understand a question, be sure to mark it so the doctor can go over it with you during the exam.

Demographics and Heredity

|   |                          |                  |                          |
|---|--------------------------|------------------|--------------------------|
| What is your ancestry? Please check each box for which your ancestry is 25% or greater. |                          |                  |                          |
| White, not of Hispanic origin   | <input type="checkbox"/> | Asian            | <input type="checkbox"/> |
| Black, not of Hispanic origin   | <input type="checkbox"/> | American Indian  | <input type="checkbox"/> |
| Hispanic  | <input type="checkbox"/> | Pacific Islander | <input type="checkbox"/> |
| Other (please specify) _____  |                          |                  |                          |

In what country were you born? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Are you retired? \_\_\_\_\_ If so, what type of work did you do? \_\_\_\_\_

Please list your hobbies, sports, and activities: \_\_\_\_\_

*Please check off one circle for each question below:*

I am currently:       married    separated    divorced    widowed    never married  
                                  in a committed long-term relationship

I have been married:    0 times    1 time    2 times    3 or more times

I am currently living:    alone    with my spouse    with my family    with a companion

My highest level of education is:       elementary school    some high school  
                                  high school diploma or GED    some college       college degree or higher

|                       |
|-----------------------|
| <b>GENERAL HEALTH</b> |
|-----------------------|

I consider my health to be:    excellent    good                                       fair                                       poor

The amount of stress I am under is:    small    moderate    large                                        
overwhelming

**In the past 12 months**

I have been to a doctor:       0 times       1-4 times       5-9 times       10 or more times

I have had to stay overnight in the hospital:    0 times       1 time       2 or more times

I regularly use seat belts in the car:  Yes  No

I currently have severe fatigue, tiredness or exhaustion:  Yes  No

|                                    | Y                     | N                     |
|------------------------------------|-----------------------|-----------------------|
| <b>I often:</b>                    |                       |                       |
| awaken tired after adequate sleep  | <input type="radio"/> | <input type="radio"/> |
| fall asleep at inappropriate times | <input type="radio"/> | <input type="radio"/> |
| am anxious or nervous              | <input type="radio"/> | <input type="radio"/> |
| am worried about being ill         | <input type="radio"/> | <input type="radio"/> |
| am irritable                       | <input type="radio"/> | <input type="radio"/> |
| feel like crying                   | <input type="radio"/> | <input type="radio"/> |
| feel hopeless or down in the dumps | <input type="radio"/> | <input type="radio"/> |
| have problems with depression      | <input type="radio"/> | <input type="radio"/> |
| feel suicidal                      | <input type="radio"/> | <input type="radio"/> |
| have attacks of feeling panicked   | <input type="radio"/> | <input type="radio"/> |

|                                   | Y                     | N                     |
|-----------------------------------|-----------------------|-----------------------|
| <b>I have:</b>                    |                       |                       |
| problems controlling anger        | <input type="radio"/> | <input type="radio"/> |
| difficulty caring for myself      | <input type="radio"/> | <input type="radio"/> |
| frequent headaches                | <input type="radio"/> | <input type="radio"/> |
| trouble falling or staying asleep | <input type="radio"/> | <input type="radio"/> |

|   | Y                     | N                     |
|---|-----------------------|-----------------------|
| Do you have an Advanced Directive (Living Will, Durable Power of Attorney for Health Care, or Directive to Physicians)? | <input type="radio"/> | <input type="radio"/> |

**NEUROLOGIC**

|                                     | Y                     | N                     |
|-------------------------------------|-----------------------|-----------------------|
| <b>Do you had or do you have:</b>   |                       |                       |
| trouble with your balance?          | <input type="radio"/> | <input type="radio"/> |
| a fall within the past year?        | <input type="radio"/> | <input type="radio"/> |
| trouble walking?                    | <input type="radio"/> | <input type="radio"/> |
| trouble remembering?                | <input type="radio"/> | <input type="radio"/> |
| problems with dizziness?            | <input type="radio"/> | <input type="radio"/> |
| ever been knocked unconscious?      | <input type="radio"/> | <input type="radio"/> |
| involuntary movements of your body? | <input type="radio"/> | <input type="radio"/> |
| a convulsion or seizure?            | <input type="radio"/> | <input type="radio"/> |

|  | Y                     | N                     |
|--|-----------------------|-----------------------|
| numbness in your hands or feet?                        | <input type="radio"/> | <input type="radio"/> |
| hand/foot paralysis for >5 min?                        | <input type="radio"/> | <input type="radio"/> |
| a temporary loss of speech?                            | <input type="radio"/> | <input type="radio"/> |
| a temporary loss of vision ?                           | <input type="radio"/> | <input type="radio"/> |
| a stroke?  | <input type="radio"/> | <input type="radio"/> |
| hallucinations at times?                               | <input type="radio"/> | <input type="radio"/> |
| a nervous breakdown?                                   | <input type="radio"/> | <input type="radio"/> |
| a brain, nerve, or emotional problem not on this list? | <input type="radio"/> | <input type="radio"/> |

**EYES**

|                                     | Y | N |
|-------------------------------------|---|---|
| <b>Have you had or do you have:</b> |   |   |

|                | Y                     | N                     |
|----------------|-----------------------|-----------------------|
| blurry vision? | <input type="radio"/> | <input type="radio"/> |

|                              |                       |                       |                                  |                       |                       |
|------------------------------|-----------------------|-----------------------|----------------------------------|-----------------------|-----------------------|
| double vision? (not blurred) | <input type="radio"/> | <input type="radio"/> | itchy eyes?                      | <input type="radio"/> | <input type="radio"/> |
|                              |                       |                       | eye pain?                        | <input type="radio"/> | <input type="radio"/> |
|                              | <input type="radio"/> | <input type="radio"/> |                                  |                       |                       |
| visual spots / floaters?     | <input type="radio"/> | <input type="radio"/> |                                  | <input type="radio"/> | <input type="radio"/> |
| color blindness?             | <input type="radio"/> | <input type="radio"/> | cataracts?                       | <input type="radio"/> | <input type="radio"/> |
| A spot in your vision?       | <input type="radio"/> | <input type="radio"/> | a retinal hemorrhage?            | <input type="radio"/> | <input type="radio"/> |
|                              | <input type="radio"/> | <input type="radio"/> | macular degeneration?            | <input type="radio"/> | <input type="radio"/> |
| A sudden loss of vision?     | <input type="radio"/> | <input type="radio"/> | a detached retina?               | <input type="radio"/> | <input type="radio"/> |
| A blind eye?                 | <input type="radio"/> | <input type="radio"/> | glaucoma?                        | <input type="radio"/> | <input type="radio"/> |
| a glass eye?                 | <input type="radio"/> | <input type="radio"/> | an eye problem not on this list? | <input type="radio"/> | <input type="radio"/> |

### EARS

|                                     |                       |                       |                                  |                       |                       |
|-------------------------------------|-----------------------|-----------------------|----------------------------------|-----------------------|-----------------------|
|                                     | <input type="radio"/> | <input type="radio"/> |                                  | <input type="radio"/> | <input type="radio"/> |
| <b>Have you had or do you have:</b> |                       |                       | frequent ear infections?         | <input type="radio"/> | <input type="radio"/> |
| trouble hearing?                    | <input type="radio"/> | <input type="radio"/> | a draining ear?                  | <input type="radio"/> | <input type="radio"/> |
| prolonged exposure to loud noise?   | <input type="radio"/> | <input type="radio"/> | a serious ear injury?            | <input type="radio"/> | <input type="radio"/> |
| tinnitus (ringing) in your ears?    | <input type="radio"/> | <input type="radio"/> | an ear problem not on this list? | <input type="radio"/> | <input type="radio"/> |
| a hearing aid that you use?         | <input type="radio"/> | <input type="radio"/> |                                  |                       |                       |

### NOSE/SINUSES

|  |                       |                       |                                 |                       |                       |
|--|-----------------------|-----------------------|---------------------------------|-----------------------|-----------------------|
|  | <input type="radio"/> | <input type="radio"/> |                                 | <input type="radio"/> | <input type="radio"/> |
| <b>Have you had or do you have:</b>                    |                       |                       |                                 | <input type="radio"/> | <input type="radio"/> |
| hay fever or allergic rhinitis?                        | <input type="radio"/> | <input type="radio"/> | frequent nose bleeds?           | <input type="radio"/> | <input type="radio"/> |
| frequent sneezing, nasal watering or nasal congestion? | <input type="radio"/> | <input type="radio"/> | nasal polyps?                   | <input type="radio"/> | <input type="radio"/> |
| mucus often draining from your nose?                   | <input type="radio"/> | <input type="radio"/> | nasal problem not on this list? | <input type="radio"/> | <input type="radio"/> |

### MOUTH, THROAT, NECK

|                                       |                       |                       |                                   |                       |                       |
|---------------------------------------|-----------------------|-----------------------|-----------------------------------|-----------------------|-----------------------|
|                                       | <input type="radio"/> | <input type="radio"/> | thyroid disease?                  | <input type="radio"/> | <input type="radio"/> |
| <b>Have you had or do you have a:</b> |                       |                       | swallowing problem?               | <input type="radio"/> | <input type="radio"/> |
| lip problem?                          | <input type="radio"/> | <input type="radio"/> | voice problem?                    | <input type="radio"/> | <input type="radio"/> |
| tooth or gum problem?                 | <input type="radio"/> | <input type="radio"/> |                                   | <input type="radio"/> | <input type="radio"/> |
| mouth, tongue, or jaw problem?        | <input type="radio"/> | <input type="radio"/> | problem with back of your throat? | <input type="radio"/> | <input type="radio"/> |

lump or swelling in neck?              

neck pain?                                  

a mouth, throat, or neck problem not  
on this list?

**LUNGS**

|                                       | Y                     | N                     |   | Y                     | N                     |
|---------------------------------------|-----------------------|-----------------------|---|-----------------------|-----------------------|
| <b>Have you had or do you have:</b>   |                       |                       |   |                       |                       |
| wheezing?                             | <input type="radio"/> | <input type="radio"/> | I have been a cigarette smoker  | <input type="radio"/> | <input type="radio"/> |
| Shortness of breath?                  | <input type="radio"/> | <input type="radio"/> | if yes, do you currently smoke?   | <input type="radio"/> | <input type="radio"/> |
| A chronic cough?                      | <input type="radio"/> | <input type="radio"/> | If yes, how many cigarettes do you smoke now  |                       |                       |
| coughing up blood in the past year?   | <input type="radio"/> | <input type="radio"/> | every day? _____  |                       |                       |
| Asthma?                               | <input type="radio"/> | <input type="radio"/> | If yes, how many years have you smoked? _____   |                       |                       |
| Emphysema?                            | <input type="radio"/> | <input type="radio"/> | I have used other tobacco products  | <input type="radio"/> | <input type="radio"/> |
| Repeated episodes of pneumonia?       | <input type="radio"/> | <input type="radio"/> | if yes, which ones: <input type="radio"/> cigars <input type="radio"/> pipe <input type="radio"/> snuff |                       |                       |
| Tuberculosis?                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> chewing tobacco   |                       |                       |
| Pulmonary embolism (blood clot lung)? | <input type="radio"/> | <input type="radio"/> | are you currently using any of these?   | <input type="radio"/> | <input type="radio"/> |
| Chronic bronchitis?                   | <input type="radio"/> | <input type="radio"/> | If yes, how many times per day? _____   |                       |                       |
| Collapsed lung?                       | <input type="radio"/> | <input type="radio"/> | <b>I have:</b>  |                       |                       |
| Sarcoid?                              | <input type="radio"/> | <input type="radio"/> | received BCG vaccine  |                       |                       |
| Frequent night sweats?                | <input type="radio"/> | <input type="radio"/> | (TB immunization)   | <input type="radio"/> | <input type="radio"/> |
| A lung or chest problem not listed?   | <input type="radio"/> | <input type="radio"/> | had a positive TB skin test   | <input type="radio"/> | <input type="radio"/> |
|                                       |                       |                       | taken INH for at least 6 months   | <input type="radio"/> | <input type="radio"/> |
|                                       |                       |                       | received Pneumovax (pneumonia shot)   | <input type="radio"/> | <input type="radio"/> |

**CARDIOVASCULAR**

|                                     | Y                     | N                     |   | Y                     | N                     |
|-------------------------------------|-----------------------|-----------------------|---|-----------------------|-----------------------|
| <b>Have you had or do you have:</b> |                       |                       |   |                       |                       |
| high blood pressure?                | <input type="radio"/> | <input type="radio"/> | a heart attack for which you were       |                       |                       |
| a cholesterol problem?              | <input type="radio"/> | <input type="radio"/> | hospitalized more than three days?      | <input type="radio"/> | <input type="radio"/> |
| a heart valve problem?              | <input type="radio"/> | <input type="radio"/> | a "clot buster" treatment for a         |                       |                       |
| an abnormal treadmill test?         | <input type="radio"/> | <input type="radio"/> | heart attack?                           | <input type="radio"/> | <input type="radio"/> |
| a coronary arteriogram?             | <input type="radio"/> | <input type="radio"/> | varicose veins?                         | <input type="radio"/> | <input type="radio"/> |
| angina pectoris (heart pains)?      | <input type="radio"/> | <input type="radio"/> | narrowing of the arteries in your neck? | <input type="radio"/> | <input type="radio"/> |
| a silent heart attack?              | <input type="radio"/> | <input type="radio"/> | a heart or circulatory problem not      |                       |                       |
| congestive heart failure?           | <input type="radio"/> | <input type="radio"/> | listed here?                            | <input type="radio"/> | <input type="radio"/> |
| abnormal blood clot formation?      | <input type="radio"/> | <input type="radio"/> |   |                       |                       |

|   | Y                     | N                     |   | Y                     | N                     |
|---|-----------------------|-----------------------|---|-----------------------|-----------------------|
| <b>Do you get:</b>  |                       |                       |   |                       |                       |
| pressure or tightness in your chest, with exertion or walking uphill? | <input type="radio"/> | <input type="radio"/> | episodes of rapid/irregular heartbeat?          | <input type="radio"/> | <input type="radio"/> |
| pain in the legs that forces you to stop walking?                     | <input type="radio"/> | <input type="radio"/> | have you ever had abnormal blood clots develop? | <input type="radio"/> | <input type="radio"/> |

**SKIN**

|                                       | Y                     | N                     |                                   | Y                     | N                     |
|---------------------------------------|-----------------------|-----------------------|-----------------------------------|-----------------------|-----------------------|
| <b>I have:</b>                        |                       |                       |                                   |                       |                       |
| a mole that has changed color or size | <input type="radio"/> | <input type="radio"/> | allergy to cosmetics or chemicals | <input type="radio"/> | <input type="radio"/> |
| a sore that doesn't heal              | <input type="radio"/> | <input type="radio"/> | allergy to medications            | <input type="radio"/> | <input type="radio"/> |
| acne                                  | <input type="radio"/> | <input type="radio"/> | If yes, please list _____         |                       |                       |
| eczema                                | <input type="radio"/> | <input type="radio"/> | history of radiation treatment    | <input type="radio"/> | <input type="radio"/> |
| psoriasis                             | <input type="radio"/> | <input type="radio"/> | darkening of the skin             | <input type="radio"/> | <input type="radio"/> |
| allergy to sunlight                   | <input type="radio"/> | <input type="radio"/> | a skin condition not listed       | <input type="radio"/> | <input type="radio"/> |

**DIGESTIVE**

|   | Y                     | N                     |  | Y                     | N                     |
|---|-----------------------|-----------------------|--|-----------------------|-----------------------|
| <b>During the last year I have had:</b> |                       |                       |  |                       |                       |
| distinct weight gain or loss            | <input type="radio"/> | <input type="radio"/> | inability to control my bowels                 | <input type="radio"/> | <input type="radio"/> |
| trouble swallowing                      | <input type="radio"/> | <input type="radio"/> | a digestion problem not on this list           | <input type="radio"/> | <input type="radio"/> |
| indigestion or heartburn                | <input type="radio"/> | <input type="radio"/> | <b>I have been diagnosed by a doctor with:</b> |                       |                       |
| recurrent nausea or vomiting            | <input type="radio"/> | <input type="radio"/> | esophagitis or esophageal reflux               | <input type="radio"/> | <input type="radio"/> |
| <b>During the last year I have had:</b> |                       |                       | hiatal hernia                                  | <input type="radio"/> | <input type="radio"/> |
| recurrent abdominal pain                | <input type="radio"/> | <input type="radio"/> | liver trouble                                  | <input type="radio"/> | <input type="radio"/> |
| an episode of vomiting blood            | <input type="radio"/> | <input type="radio"/> | gallbladder problems                           | <input type="radio"/> | <input type="radio"/> |
| a change in bowel habits                | <input type="radio"/> | <input type="radio"/> | peptic ulcer                                   | <input type="radio"/> | <input type="radio"/> |
| frequent diarrhea                       | <input type="radio"/> | <input type="radio"/> | gastrointestinal bleeding                      | <input type="radio"/> | <input type="radio"/> |
| chronic constipation                    | <input type="radio"/> | <input type="radio"/> | irritable bowel syndrome                       | <input type="radio"/> | <input type="radio"/> |
| visible blood in bowel movement         | <input type="radio"/> | <input type="radio"/> | intestinal polyps                              | <input type="radio"/> | <input type="radio"/> |
| black, tar-like, bowel movements        | <input type="radio"/> | <input type="radio"/> | abdominal hernia (rupture)                     | <input type="radio"/> | <input type="radio"/> |
|   | Y                     | N                     |  | Y                     | N                     |

**I have been diagnosed by a doctor with:**

- hemochromatosis  Y  N
- hepatitis  Y  N
- diabetes or borderline diabetes  Y  N
- a gastrointestinal problem not on the list  Y  N

**In the past 10 years I have had a:**

- barium enema  Y  N
- colonoscopy  Y  N
- sigmoidoscopy  Y  N

**I am:**

- a vegetarian  Y  N
- a strict vegetarian who also avoids fish and dairy  Y  N
- likely to have some form of alcohol:  
 never  hardly ever  < 3 times a week  
 > three times per week  daily

I sometimes wonder if I drink more than is good for me  Y  N

Was there ever a time when you often drank five or more drinks a day of any kind of alcoholic beverage?  Y  N

**SURGERY**

**Have you had any of the following surgical operations:**

- prostate surgery?  Y  N
- vasectomy?  Y  N
- breast biopsy?  Y  N
- lumpectomy?  Y  N
- mastectomy?  Y  N
- breast implants?  Y  N
- tubal ligation?  Y  N
- hysterectomy?  Y  N
- bladder surgery?  Y  N
- abdominal aortic aneurysm?  Y  N
- angioplasty?  Y  N
- appendectomy?  Y  N
- cholecystectomy (gallbladder)?  Y  N

- eye or ear surgery?  Y  N
- heart valve replacement?  Y  N
- hernia repair?  Y  N
- kidney surgery?  Y  N
- peptic ulcer surgery?  Y  N
- thyroid surgery?  Y  N
- artificial joint implant?  Y  N
- disc or other back surgery?  Y  N
- other bone surgery?  Y  N
- surgery not on this list?  Y  N

**Have you ever been diagnosed with the following cancers?**

- lung?  Y  N
- blood or lymphatic?  Y  N
- bladder?  Y  N
- colon?  Y  N
- skin?  Y  N
- breast?  Y  N

**Have you had any of the following surgical operations:**

- coronary bypass?  Y  N
- carpal tunnel release?  Y  N

|         |                       |                       |                         |                       |                       |
|---------|-----------------------|-----------------------|-------------------------|-----------------------|-----------------------|
| cervix? | <input type="radio"/> | <input type="radio"/> | testicle?               | <input type="radio"/> | <input type="radio"/> |
| uterus? | <input type="radio"/> | <input type="radio"/> | prostate?               | <input type="radio"/> | <input type="radio"/> |
| ovary?  | <input type="radio"/> | <input type="radio"/> | Any other cancer? _____ |                       |                       |
|         | <b>Y</b>              | <b>N</b>              |                         |                       |                       |

**MUSCULOSKELETAL**

|   | <b>Y</b>              | <b>N</b>              |  | <b>Y</b>              | <b>N</b>              |
|---|-----------------------|-----------------------|--|-----------------------|-----------------------|
| <b>I have had:</b>                          |                       |                       | a musculoskeletal problem not on this list |                       |                       |
| a leg fracture                              | <input type="radio"/> | <input type="radio"/> |  | <input type="radio"/> | <input type="radio"/> |
| a fracture of the pelvis                    | <input type="radio"/> | <input type="radio"/> | <b>I have been diagnosed with:</b>         |                       |                       |
| a fracture other than listed                | <input type="radio"/> | <input type="radio"/> | rheumatoid arthritis                       | <input type="radio"/> | <input type="radio"/> |
| a bone or ligament injury that never healed | <input type="radio"/> | <input type="radio"/> | osteoarthritis                             | <input type="radio"/> | <input type="radio"/> |
| polio                                       | <input type="radio"/> | <input type="radio"/> | psoriatic arthritis                        | <input type="radio"/> | <input type="radio"/> |
| <b>I currently have:</b>                    |                       |                       | other forms of arthritis                   | <input type="radio"/> | <input type="radio"/> |
| night time leg cramps                       | <input type="radio"/> | <input type="radio"/> | osteoporosis                               | <input type="radio"/> | <input type="radio"/> |
| pain or stiffness in my joints on most days | <input type="radio"/> | <input type="radio"/> | lupus                                      | <input type="radio"/> | <input type="radio"/> |
|   |                       |                       | fibrositis or fibromyalgia                 | <input type="radio"/> | <input type="radio"/> |

**MEN'S HEALTH**

|   | <b>Y</b>              | <b>N</b>              |  | <b>Y</b>              | <b>N</b>              |
|---|-----------------------|-----------------------|--|-----------------------|-----------------------|
| <b>I have had:</b>                            |                       |                       | pain or burning with urination                               | <input type="radio"/> | <input type="radio"/> |
| prostatitis                                   | <input type="radio"/> | <input type="radio"/> | blood in urine   | <input type="radio"/> | <input type="radio"/> |
| a kidney stone                                | <input type="radio"/> | <input type="radio"/> | problems getting an erection                                 | <input type="radio"/> | <input type="radio"/> |
| <b>I currently have:</b>                      |                       |                       | problem with impotence or maintaining an erection during sex | <input type="radio"/> | <input type="radio"/> |
| problem starting or stopping urine            | <input type="radio"/> | <input type="radio"/> | a urinary, sexual, or men's health problem not on this list  | <input type="radio"/> | <input type="radio"/> |
| occasional loss of urine                      | <input type="radio"/> | <input type="radio"/> |  |                       |                       |
| reduced urine strain                          | <input type="radio"/> | <input type="radio"/> |  |                       |                       |
| to get up several times each night to urinate | <input type="radio"/> | <input type="radio"/> |  |                       |                       |



|                       |
|-----------------------|
| <b>WOMEN'S HEALTH</b> |
|-----------------------|

|  | Y                     | N                     |
|--|-----------------------|-----------------------|
| <b>I have a:</b>   |                       |                       |
| lump in my breast  | <input type="radio"/> | <input type="radio"/> |
| nipple discharge   | <input type="radio"/> | <input type="radio"/> |
| problem with breast tenderness or pain                         | <input type="radio"/> | <input type="radio"/> |
| has your physician ever recommended that you have a mammogram? | <input type="radio"/> | <input type="radio"/> |
| My last mammogram was _____                                    |                       |                       |

How often do you do your own breast exam? \_\_\_\_\_

|   |                       |                       |
|---|-----------------------|-----------------------|
| <b>I have had:</b>                                |                       |                       |
| a breast biopsy or aspiration that was NOT cancer | <input type="radio"/> | <input type="radio"/> |
| a lumpectomy for cancer                           | <input type="radio"/> | <input type="radio"/> |
| a mastectomy for cancer                           | <input type="radio"/> | <input type="radio"/> |
| fibrocystic breast diagnosis                      | <input type="radio"/> | <input type="radio"/> |
| a breast problem not on the list                  | <input type="radio"/> | <input type="radio"/> |

|                       |                       |                       |
|-----------------------|-----------------------|-----------------------|
| <b>I have:</b>        |                       |                       |
| vaginal itching       | <input type="radio"/> | <input type="radio"/> |
| a vaginal discharge   | <input type="radio"/> | <input type="radio"/> |
| vaginal dryness       | <input type="radio"/> | <input type="radio"/> |
| pain with intercourse | <input type="radio"/> | <input type="radio"/> |
| chronic pelvic pain   | <input type="radio"/> | <input type="radio"/> |

|                                    |                       |                       |
|------------------------------------|-----------------------|-----------------------|
| <b>I am:</b>                       |                       |                       |
| currently pregnant                 | <input type="radio"/> | <input type="radio"/> |
| still having menstrual periods     | <input type="radio"/> | <input type="radio"/> |
| definitely in menopause            | <input type="radio"/> | <input type="radio"/> |
| not certain about my present state | <input type="radio"/> | <input type="radio"/> |

|                          |                       |                       |
|--------------------------|-----------------------|-----------------------|
| <b>I currently have:</b> |                       |                       |
| no periods               | <input type="radio"/> | <input type="radio"/> |
| regular periods          | <input type="radio"/> | <input type="radio"/> |
| irregular periods        | <input type="radio"/> | <input type="radio"/> |

|  | Y                     | N                     |
|--|-----------------------|-----------------------|
| heavy periods  | <input type="radio"/> | <input type="radio"/> |
| a lot of pain with my periods                          | <input type="radio"/> | <input type="radio"/> |
| bleeding or spotting between periods                   | <input type="radio"/> | <input type="radio"/> |
| vaginal spotting after I thought menopause had started | <input type="radio"/> | <input type="radio"/> |

|                                    |                       |                       |
|------------------------------------|-----------------------|-----------------------|
| <b>I have:</b>                     |                       |                       |
| loss of urine                      | <input type="radio"/> | <input type="radio"/> |
| pain or burning with urination     | <input type="radio"/> | <input type="radio"/> |
| had blood in my urine              | <input type="radio"/> | <input type="radio"/> |
| to urinate frequently              | <input type="radio"/> | <input type="radio"/> |
| repeated urinary infections        | <input type="radio"/> | <input type="radio"/> |
| a urinary problem not on this list | <input type="radio"/> | <input type="radio"/> |

|  |                       |                       |
|--|-----------------------|-----------------------|
| <b>I have had:</b>                               |                       |                       |
| an infected tube, PID, or other pelvic infection | <input type="radio"/> | <input type="radio"/> |
| glomerulonephritis                               | <input type="radio"/> | <input type="radio"/> |
| ectopic pregnancy                                | <input type="radio"/> | <input type="radio"/> |
| a kidney stone                                   | <input type="radio"/> | <input type="radio"/> |
| pyelonephritis                                   | <input type="radio"/> | <input type="radio"/> |
| my last Pap smear was _____                      |                       |                       |
| what type of birth control do you currently use  |                       |                       |

\_\_\_\_\_

how many pregnancies have you had \_\_\_\_\_

how many births have you had \_\_\_\_\_

|  |                       |                       |
|--|-----------------------|-----------------------|
| <b>I have had:</b>   |                       |                       |
| reproductive, urinary, or sexual problems that are not mentioned | <input type="radio"/> | <input type="radio"/> |
| abnormal blood clots during pregnancy                            | <input type="radio"/> | <input type="radio"/> |
| other abnormal blood clots in the past                           | <input type="radio"/> | <input type="radio"/> |
| to be taken off the pill because of clotting problems            | <input type="radio"/> | <input type="radio"/> |

**FAMILY HISTORY**

**I am:**  
 adopted  Y  N I have \_\_\_\_\_ brothers  
 an identical twin  O  O I have \_\_\_\_\_ sisters  
 One of my children has serious health or emotional problems  O  O  
 Some primary members of my family died before age 65  O  O

Please check any appropriate boxes. **The following have occurred in my biologic family:**

|  | Mother | Father | Brothers | Sisters | Children | Grandparents |
|--|--------|--------|----------|---------|----------|--------------|
| Heart attack   |        |        |          |         |          |              |
| High blood pressure                                  |        |        |          |         |          |              |
| Diabetes   |        |        |          |         |          |              |
| Cancer   |        |        |          |         |          |              |
| Stroke   |        |        |          |         |          |              |
| Abnormal blood clots                                 |        |        |          |         |          |              |
| Alcoholism   |        |        |          |         |          |              |
| Illegal or street drug use                           |        |        |          |         |          |              |
| Liver problems                                       |        |        |          |         |          |              |
| Any rare hereditary disease                          |        |        |          |         |          |              |
| Depression   |        |        |          |         |          |              |
| Suicide  |        |        |          |         |          |              |
| Serious health or emotional problem                  |        |        |          |         |          |              |
| If deceased, please write the age in which they died |        |        |          |         |          |              |

|                              |
|------------------------------|
| <b>SOCIAL/SEXUAL HISTORY</b> |
|------------------------------|

**Important:** This information is **confidential**. It will be placed in a section of your medical chart that cannot be duplicated if your medical record is ever copied for health companies, employers, etc. This information is helpful for your medical treatment, but if you do not feel comfortable filling out any section, you may leave it blank.

|   | Y                     | N                     |  | Y                     | N                     |
|---|-----------------------|-----------------------|--|-----------------------|-----------------------|
| <b>I am:</b>  |                       |                       | <b>I have:</b>   |                       |                       |
| a virgin  | <input type="radio"/> | <input type="radio"/> | been physically abused as a child                            | <input type="radio"/> | <input type="radio"/> |
| not sexually active within the past year                | <input type="radio"/> | <input type="radio"/> | been verbally abused as a child                              | <input type="radio"/> | <input type="radio"/> |
| no longer sexually active                               | <input type="radio"/> | <input type="radio"/> | been sexually molested as a child or adolescent              | <input type="radio"/> | <input type="radio"/> |
| sexually active with a male partner                     | <input type="radio"/> | <input type="radio"/> | been raped   | <input type="radio"/> | <input type="radio"/> |
| sexually active with a female partner                   | <input type="radio"/> | <input type="radio"/> | been threatened or abused as an adult by a sexual partner    | <input type="radio"/> | <input type="radio"/> |
| sexually active with more than one partner at this time | <input type="radio"/> | <input type="radio"/> | Has your partner ever threatened, pushed, or shoved you?     | <input type="radio"/> | <input type="radio"/> |
| satisfied with my sex life                              | <input type="radio"/> | <input type="radio"/> | Have you ever threatened, pushed, or shoved your partner?    | <input type="radio"/> | <input type="radio"/> |
| <b>I am:</b>  |                       |                       | Have you ever had a partner threaten or abuse your children? | <input type="radio"/> | <input type="radio"/> |
| possibly at risk for AIDS                               | <input type="radio"/> | <input type="radio"/> |  |                       |                       |
| diagnosed with HIV/AIDS                                 | <input type="radio"/> | <input type="radio"/> | <b>I am having serious problems with:</b>                    |                       |                       |
| <b>I have had:</b>                                      |                       |                       | my marriage  | <input type="radio"/> | <input type="radio"/> |
| urethritis  | <input type="radio"/> | <input type="radio"/> | my family  | <input type="radio"/> | <input type="radio"/> |
| genital herpes  | <input type="radio"/> | <input type="radio"/> | my job   | <input type="radio"/> | <input type="radio"/> |
| gonorrhea   | <input type="radio"/> | <input type="radio"/> | finances   | <input type="radio"/> | <input type="radio"/> |
| syphilis  | <input type="radio"/> | <input type="radio"/> | drug or alcohol use  | <input type="radio"/> | <input type="radio"/> |
| a sexually transmitted disease not on this list         | <input type="radio"/> | <input type="radio"/> | work-related injuries  | <input type="radio"/> | <input type="radio"/> |
|   |                       |                       | have you ever used street drugs, even one time?              | <input type="radio"/> | <input type="radio"/> |

**Patient Registration**

Name \_\_\_\_\_ Home phone ( \_\_\_\_ ) \_\_\_\_\_  
Address \_\_\_\_\_ Cell phone ( \_\_\_\_ ) \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone ( \_\_\_\_ ) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Phone Number ( \_\_\_\_ ) \_\_\_\_\_ Referred by \_\_\_\_\_

**Insurance and Billing Information**

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

**Assignment of Insurance Benefits**

I hereby authorize direct payment of surgical/medical benefits to Dr. Sun, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**Authorization to Release Information**

I hereby authorize Dr. Sun to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

**Medicare/Medicaid**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

**A photocopy of these assignments shall be valid as the original**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

It is our office policy to try to contact every patient by phone whenever follow-up information needs to be given for test results, further care needs, etc. Most of these calls will be made during business hours, and we often encounter only message machines or voice mail when we make calls. Please provide the telephone number that you would prefer us to use to contact you about your medical information and needs.

Daytime Telephone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Please check one of the following to indicate your wishes:

\_\_\_\_\_ 1. Dr. Sun or his staff may leave medical information on my answering machine or voice mail. This may include test results, diagnosis, and recommendations

Or

\_\_\_\_\_ 2. I would like Dr. Sun or his staff to leave only a message to return their call. I acknowledge that this may delay my receipt of important information

Signed \_\_\_\_\_ Date \_\_\_\_\_

### ELECTRONIC MAIL

In addition, we may soon be implementing e-mail as a means to communicate certain specific information. This may include appointment reminders, cholesterol and diabetes test results, or perhaps other laboratory results. Significantly abnormal results will still be communicated by telephone. Additionally, the law states that information regarding hepatitis testing, HIV antibody testing, the abuse of drugs, and tests of body tissues such biopsies or Pap smears, can never be transmitted by e-mail. You must realize, however, that **email is not a secure means of communication, and it may reach sources other than those you intend.** Also, please do not provide a work e-mail address, as all company e-mail is usually saved on work computers regardless of whether the message has been erased, and your medical information should not be readily available to your employer. Please check one of the following:

\_\_\_\_\_ 1. I prefer not to use e-mail for communication

Or

\_\_\_\_\_ 2. When it becomes available, I would like Dr. Sun or his staff to contact me by e-mail for appointment reminders, test results, and recommendations. I understand that e-mail is not a totally secure means of information transmission

Home e-mail address (please print) \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Notice of Privacy Practices**

Effective Date: April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services.

**Uses And Disclosures of Protected Health Information**

Your protected health information (PHI) may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of physicians practice, and any other use required by law.

**Treatment:** we will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to, in order to ensure that the physician has all necessary information to diagnose or treat you.

**Payment:** Your PHI will be used, as necessary, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant PHI be disclose to the health plan to obtain approval for the hospital admission.

**Health care operations:** we may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointments.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements;

Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activities; Military Activity and National Security; Workers' Compensation; Inmates; and Required Uses And Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses And Disclosures** will be made only with your consent, authorization, or opportunity to object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

#### Your Rights

**You have the right to inspect and copy your PHI.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

**You have the right to request a restriction of your PHI.** This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You will then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

**You may have the right to have your physician amend your PHI.** If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

#### Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer. We will not retaliate against you for filing a complaint.

**Wynnshang C. Sun, M.D., APC**  
**Diplomate, American Board of Internal Medicine**  
9850 Genesee Avenue • Suite 870  
La Jolla, California 92037

Telephone  
(858) 452-7040

Facsimile  
(858) 452-7137

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**Acknowledgment of Receipt of Notice of Privacy Practices**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name and Address of Patient: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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*Complete the following only if the patient refuses to sign:*

Reasons for refusal: \_\_\_\_\_  
\_\_\_\_\_