

Name:(Last, First, M.I.) \_\_\_\_\_, \_\_\_\_\_ How did you hear about us?: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Medical Problems/ Hospitalizations/ Surgeries:**
**Date**

- |          |           |
|----------|-----------|
| 1) _____ | 6) _____  |
| 2) _____ | 7) _____  |
| 3) _____ | 8) _____  |
| 4) _____ | 9) _____  |
| 5) _____ | 10) _____ |

**Allergies to:**  None  Latex  Iodine/Shellfish  Anesthetic  Medications: \_\_\_\_\_

**Medications:** (include BCP, calcium, vitamins, aspirin, herbs)

**Dosage**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Social History:** Occupation: \_\_\_\_\_  Married  Single  Divorced  Widowed  Other \_\_\_\_\_

 Smoker:  No  Yes, I smoke \_\_\_\_\_ Pack(s) a Day for \_\_\_\_\_ Years.

 Alcohol:  No  Yes, I have \_\_\_\_\_ Drink(s) a Day for \_\_\_\_\_ Years.

 Coffee:  No  Yes, I drink \_\_\_\_\_ cup(s) a Day for \_\_\_\_\_ Years.

Interesting Fact About Yourself? \_\_\_\_\_

**Family:**

	Age	Medical Problems	Deceased		M	F	Age	Medical Problems	Deceased
Father	_____	_____	<input type="checkbox"/>	Children	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
Mother	_____	_____	<input type="checkbox"/>	Children	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
Brother/Sister	_____	_____	<input type="checkbox"/>	Children	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
Brother/Sister	_____	_____	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
Brother/Sister	_____	_____	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>

**Review of Systems:** (Check all that apply)

Last menses: \_\_\_\_\_ Birth control method: \_\_\_\_\_

***I have:***  Pacemaker  Defibrillator  Valve Replacement  Diabetes  Coumadin/Anticoagulation Use

	Past	Current		Past	Current		Past	Current
<u>Constitutional</u>			<u>Endocrine</u>			<u>Gastroenterology</u>		
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<u>Hematology/Oncology</u>			Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEENT/Neurology</u>			Bleeding/Clotting Problem	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/-strokes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	<u>Rheum/Derm</u>			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hearing/Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Pains	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory</u>			Immune Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Bloody/Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia/Bronchitis/TB	<input type="checkbox"/>	<input type="checkbox"/>	<u>Urology</u>			Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulosis/Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cardiology</u>			Urinary infections	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal discomfort/pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	(Office use: 10+ complete)		
Rheumatic Fever/Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<u>Psychology</u>			Last colonoscopy (date): _____		
Antibiotics before dentist	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	Any blood tests recently? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Leg Swelling/Cramping	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Preferred lab (circle one): Quest or Labcorp or Sutter Mills-Peninsula		

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Reviewed &amp; Updated: \_\_\_\_\_



**Acknowledgement of Receipt of Notice of Privacy Practices**

To Our Patients:

In accordance with Federal Law on the Patient Privacy, please read the following:

This statement is to advise you that our office has a Privacy Policy (complete policy in waiting room) in place to protect your medical information. In brief, our policy states that our office will keep your medical record information confidential and will use it only for treatment, payment and healthcare operations. The office may release information to other doctors during emergencies, or cases of neglect and abuse. Our policy identifies your rights to access your records, request restrictions on who can see and be informed of your medical information. In short, to keep your communications with this office confidential.

Our Privacy Policy can be reviewed in its entirety, or you may request a copy.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship: \_\_\_\_\_

You have my permission to release my medical information to the following: *(please check and list name and phone number)*

- Patient Only
- Spouse/domestic partner: \_\_\_\_\_
- Others: \_\_\_\_\_

Would you like information regarding Advanced Directives?  Yes  No



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F 650 3423239  
www.mygidoctors.com

Date: \_\_\_\_\_ Primary care physician: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
(last) (first) (middle)

Address: \_\_\_\_\_  
City State Zip Code

Billing Address (if different from above): \_\_\_\_\_

Phone #'s  
Home:  \_\_\_\_\_ Cell:  \_\_\_\_\_ email: \_\_\_\_\_  
(check preferred number)

Marital Status: \_\_\_\_\_ Birthdate: (MM/DD/YY) \_\_\_\_\_ Sex:  M /  F

Ethnicity:  Hispanic or Latino /  Not Hispanic or Latino

Race (check one box that best describes you):  Asian  Black/African American  Hispanic or Latino  Native American  Native Hawaiian or Other Pacific Islander  White/Caucasian  Multiracial  Other \_\_\_\_\_  Unknown/Not Reported  I prefer not to answer

Preferred Spoken Language (if other than English): \_\_\_\_\_  I prefer not to answer

S.S.#: \_\_\_\_\_ (optional, unless needed for insurance billing purposes please complete)

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Spouse/Domestic Partner: \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact (if different from above): \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Insurance: \_\_\_\_\_  
(we would like photocopy of all your insurance cards)

Other Insurance: \_\_\_\_\_

**I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED CHARGES. PAYMENT IS DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT MY CREDIT CARD IS ON FILE AND THAT ANY REMAINING BALANCE I OWE MAY BE CHARGED TO MY CREDIT CARD. I ALSO AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY FOR THE PROCESSING OF MY INSURANCE CLAIMS. HMO PATIENTS WHO DO NOT HAVE PRIOR AUTHORIZATION TO SEE DR. ONUMA OR DR. LEE WILL BE FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED.**

Insured's Signature: \_\_\_\_\_ Date: \_\_\_\_\_