CENTRAL VALLEY ENDOCRINOLOGY

515 W Grangeville Blvd
Hanford, CA 93230
(559) 587-1100

1124 N. Chinowth St., Suite 102
Visalia, CA 93291
(559) 713-6869

Patient Information Form

PLEASE PRINT

NAME _____ DATE _____

ADDRESS _____ CITY _____ ZIP CODE _____

HOME PHONE:_____ WORK PHONE _____ SSN _____

DATE OF BIRTH _____ SEX: ☐ **M** ☐ **F** MARITAL STATUS: ☐ **M** ☐ **F** ☐ **S** ☐ **D**

REFERRING PHYSICIAN/SOURCE _____

EMPLOYER _____ ADDRESS _____ PHONE _____

SPOUSE'S NAME _____ SPOUSE'S SSN _____

SPOUSE'S EMPLOYER _____ PHONE _____

IN CASE OF EMERGENCY:

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU _____

PHONE _____ RELATIONSHIP _____

RESPONSIBLE PARTY IF UNDER 18:

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____

INSURANCE INFORMATION:

PRIMARY INSURANCE OR INDUSTRIAL CARRIER _____

SUBSCRIBER'S NAME _____ SSN _____ DOB _____

GROUP # _____ POLICY # _____

SECONDAY INS. NAME _____ SSN _____ DOB _____

GROUP # _____ POLICY # _____ RELATIONSHIP _____

I REQUEST THAT PAYMENT UNDER MY INSURANCE PROGRAM BE MADE TO EITHER ME OR ON MY BEHALF TO PREM SAHASRANAM, MD FOR ANY SERVICES FURNISHED TO ME BY THE CLINIC. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PURPOSE OF EVALUATING BENEFITS OR PROCESSING OF A CLAIM.

IN THE EVENT THAT I DO NOT PAY FOR SERVICES PROVIDED BY THIS OFFICE AND THE ACCOUNT IS PLACED FOR COLLECTION, I OR WE UNDERSTAND AND AGREE THAT AN ADDITIONAL AMOUNT EQUAL TO 40% OF THE BALANCE OWING AT THE TIME THE ACCOUNT IS PLACED FOR COLLECTION WILL BE ADDED TO THE CURRENT BALANCE OWING. IN ADDITION TO A COLLECTION FEE OF 40% OF THE BALANCE OWED, I OR WE AGREE TO PAY INTEREST AT THE RATE OF 10% PER ANNUM UNTIL THE AMOUNT OWED IS PAYED IN FULL. I OR WE FURTHER AGREE TO PAY ALL ATTORNEYS FEES AND COURT COSTS NECESSARY TO COLLECT THIS BALANCE. I AGREE TO A $25.00 CHARGE FOR A MISSED APPOINTMENT NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE OF THE DATE OF MY SCHEDULED APPOINTMENT. THIS CHARGE CANNOT BE BILLED TO MY INSURANCE.

_____ _____

SIGNATURE (PATIENT OR GUARANTOR, IF MINOR) DATE

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PREM SAHASRANAM, M.D.

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MEDICAL HISTORY QUESTIONNAIRE FORM

NAME _____ DATE _____

Date of Birth: _____ Height: _____ Weight _____

INITIAL HISTORY

1. Why are you coming to the doctor? _____

_____

2. Referring Physician: _____

3. Have you ever had any of the following? (Please check)

- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Cancer: (specify)
- ☐ Other: (specify)
- ☐ Stroke
- ☐ Heart Attack
- ☐ Angina
- ☐ Thyroid Problems
- ☐ History of Radiation
- ☐

4. List any surgeries that you have had:

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Surgery: _____ Year: _____

5. List any past hospitalizations:

When: _____ Why: _____

When: _____ Why: _____

When: _____ Why: _____

6. What medications are you taking?

List current medications including over-the-counter medications such as diet or allergy pills or herbal supplements:
(*If more space is needed, please provide the rest of medications on the back of this page.)*

Medication	**Dose**	**Frequency**

If Diabetic, see Diabetes Questionnaire

7. Are you allergic to any medications? ☐ Yes ☐ No

If yes, which ones: _____

_____

8. Family History

A. Do you have family members with diabetes? ☐ Yes ☐ No

Name _____ Relationship _____

B. Do you have family members with a thyroid problem? ☐ Yes ☐ No

Name _____ Relationship _____

C. Please check if <u>blood related</u> members of your family have had any of the following:

☐ Heart Disease	☐ High Blood Pressure	☐ Obesity
☐ Stroke	☐ High Cholesterol	☐ Breast Cancer
☐ Menstrual Problem	☐ Prostate Cancer	☐ Bone Problem
☐ Adrenal Problem	☐ Pituitary Problem	☐

9. Immunization **When**

Flu Shot _____

Pneumonia Vaccine _____

10. Social History

A. MARITAL STATUS: ☐ **M** ☐ **F** ☐ **S** ☐ **D**

B. **Alcohol Use** (# of drinks per week) **Tobacco Use** (# of packs per day)

☐ 0 _____

☐ Occasional If former smoker, how long ago did you quit?

☐ 1-6 _____

☐ 7-12

C. Education completed? ☐ Grade School ☐ High School ☐ College

D. Any history of illicit drug use? ☐ Yes ☐ No

11. Current Symptoms

A. General

Weight gain	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No

B. Skin

Hair loss	☐ Yes	☐ No	_____
Itching	☐ Yes	☐ No	_____
Dryness	☐ Yes	☐ No	

C. Eyes, Ears, Nose & Throat

Blurred vision (recent)	☐ Yes	☐ No	
Cataract	☐ Yes	☐ No	
Laser Treatment (not LASIK)	☐ Yes	☐ No	When? _____

D. Chest

Cough	☐ Yes	☐ No	_____
Shortness of breath	☐ Yes	☐ No	_____

	Yes	No
Cardiovascular:		
Chest pain	☐	☐
Palpitations	☐	☐
Shortness of breath w/ exertion	☐	☐
Shortness of breath while lying flat	☐	☐
Swelling of the legs/ankles	☐	☐
Painful legs while walking	☐	☐
Foot ulcers	☐	☐
Urinary		
Frequent urination	☐	☐
Problems starting stream	☐	☐
incontinence	☐	☐
Musculoskeletal		
Arthritis	☐	☐
What joints bother you the most _____		
Tendonitis/Bursitis	☐	☐
Back or neck pain	☐	☐
Neurological		
Frequent headaches	☐	☐
Burning sensation in the Feet and hands	☐	☐
Depressed	☐	☐
Mood swings	☐	☐

	Yes	No
Gastrointestinal:		
Loss of appetite	☐	☐
Excessive hunger	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Loose bowel movements (diarrhea)	☐	☐
Genital		
Libido (desire) Normal / Low	☐	☐
Men		
Erection problems	☐	☐
Women		
Regular periods	☐	☐
No. of Pregnancies	_____	
Menopause @ Age		
☐ natural	☐	☐
☐ surgical	☐	☐
Age periods started	_____	
Last menstrual period	_____	

If you are seeing Dr. Sahasranam for Diabetes, please fill out the Diabetic First Questionnaire, as well.

_____ _____

Patient Signature Date

_____ _____

Prem Sahasranam, M.D. (Reviewed with patient) Date