CENTRAL VALLEY ENDOCRINOLOGY
515 Granger Blvd.
Hanford, CA 93230

Patient Information Form

PLEASE PRINT

NAME _____ DATE _____

ADDRESS _____ CITY _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ SSN _____

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

REFERRING PHYSICIAN/SOURCE _____

EMPLOYER _____ ADDRESS _____ PHONE _____

SPOUSE'S NAME _____ SPOUSE'S SSN _____

SPOUSE'S DOB _____ SPOUSE'S EMPLOYER _____ PHONE _____

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU _____

PHONE _____ RELATIONSHIP _____

RESPONSIBLE PARTY IF UNDER 18:

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____

PRIMARY INSURANCE OR INDUSTRIAL CARRIER _____

SUBSCRIBER'S NAME _____ SSN _____ DOB _____

ID # _____ GROUP # _____

INSURED _____ RELATIONSHIP TO PATIENT _____

SECONDAY INS. _____ SSN _____ DOB _____

GROUP # _____ POLICY # _____ RELATIONSHIP _____

INSURED _____ RELATIONSHIP TO PATIENT _____

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

09/12/19

CENTRAL VALLEY ENDOCRINOLOGY

PREM SAHASRANAM, M.D.

515 Granger Blvd.,
Hanford, CA 93230
Phone (559) 587-1100 FAX (559) 587-9044

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** ☐ **W** ☐ **S** ☐ **D**

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

- ☐ 0
- ☐ Occasional
- ☐ 1-6
- ☐ 7-12

Tobacco Use

(# of packs per day) _____

If former smoker, how long ago did you quit?

_____

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

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

11. Current Symptoms

A. General

Weight gain	☐	How much? _____	pounds
Weight loss	☐	How much? _____	pounds
Weakness	☐		
Fatigue	☐		

B. Skin

Hair loss	☐
Itching	☐
Dryness	☐

C. Eyes, Ears, Nose & Throat

Blurred vision (recent)	☐	
Cataract	☐	
Laser Treatment (not LASIK)	☐	When? _____

D. Chest

Cough	☐
Shortness of breath	☐

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 ☐

Gastrointestinal:

- Loss of appetite ☐
- Excessive hunger ☐
- Heartburn ☐
- Nausea ☐
- Abdominal pain ☐
- Constipation ☐
- Loose bowel movements (diarrhea) ☐

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 ☐

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