CENTRAL VALLEY ENDOCRINOLOGY
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 ______________ 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

CENTRAL VALLEY ENDOCRINOLOGY

PREM SAHASRANAM, M.D.

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

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

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 blood related members of your family have had any of the following:

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

9. Immunization **When**

Flu Shot ________________

Pneumonia Vaccine ________________

10. Social History

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

B. <u>Alcohol Use</u> (# of drinks per week)

- ☐ 0
- ☐ Occasional
- ☐ 1-6
- ☐ 7-12

<u>Tobacco Use</u>

(# 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