

Patient Name:			DOB:	
	Last	First	Middle	
Today's Date:			; MRN:	
Person Filling t	his Annlicat	ion Name		

I I ALISE	Person Filling tl	his Application Name:		
Patient Information				
Name:		Date: _		
Address:				
Home / Cell Phone:		Email:		
Social Security #:		DOB:		
Government ID Type:	Number:	Exp.:		
Primary Care Physician		4		
Name:	Tele	phone #:		
Address:				
Address	City	State	Zip	
Insurance Information	100			
Insurance Name:	Su	bscrib <mark>er I.D.:</mark>		
Group Policy Number:				
Employer Information	[] Currently Employed [] Unemployed[] Retired	[] Legally Disabled	
Company Name:		Telephone #:		
Address:				
Address	City	State	Zip	
Emergency Contact				
Name:	Phone #:	Relationship:		
Address:				
Address	City	State	Zip	
Preferred Pharmacy				
Name:	Telep	hone #:		
	·			
Address	City		Zip	









	Patient Name:			<i>D</i> C	<i></i>	
	1	Last	First	Middle		
YTALISE	Today's Date:			; MRN:		
ITALISE						
	Person Filling thi	s Applicati	on Name:			
Please complete all fields:						
Patient Medical History: (M	edical Problem/ Date Dia	agnosed)				
and the angle of the control of the	culturi robicin, pate pie			Resolved [Yes	□ No
				Resolved [
						□ Nc
				Resolved [□ Nc
				Resolved [□ No
				Resolved [Yes	□ Nc
		1				
Patient Surgical History: (Su	rgery/ Date/ Reason)	An				
		100				
		18				
		100				
	7 .					
	*		7			
			7			
		1	7			
ist Allergies (Medications, fo	pod and products):	1				
.ist Allergies (Medications, fo	ood and products):	1				
.ist Allergies (Medications, fo	ood and products):					
		1				
MEDICATION LIST (name of 8	& amount taken/day):					
MEDICATION LIST (name of &	& amount taken/day):					
List Allergies (Medications, for MEDICATION LIST (name of 8	& amount taken/day):					
MEDICATION LIST (name of 8 1	& amount taken/day):					
MEDICATION LIST (name of 8 1. 2. 3.	& amount taken/day):					
MEDICATION LIST (name of 8	& amount taken/day):					
MEDICATION LIST (name of 8 1. 2. 3. 4.	& amount taken/day):					
MEDICATION LIST (name of 8 1. 2. 3. 4.	& amount taken/day):					
MEDICATION LIST (name of 8 2. 3. 4. 5. 6. 6. 6. 6. 6. 6. 6. 6. 6	& amount taken/day):					
MEDICATION LIST (name of 8 1. 2. 3. 4. 5. Family History:	& amount taken/day):					
MEDICATION LIST (name of 8 1. 2. 3. 4. 5. Family History:	& amount taken/day):					



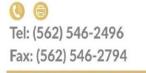














Patient Gynecological History: Age at first period Is your period regular ☐ Yes ☐ No Duration (in days) Frequency of periods (in days) Amount: Light Moderate Heavy: Number of pads per day: ______ Are you currently sexually active? ☐ Yes ☐ No How long with current partner? Unusual Vaginal Discharge ☐ Yes ☐ No Unusual itching/odor ☐ Yes ☐ No Method of Birth Control used: Abnormal Pap-smear ☐ Yes ☐ No Date of Last Pap-smear: Date of Last Colonoscopy: _____ Abnormal Colonoscopy ☐ Yes ☐ No □ No Abnormal Mammogram ☐ Yes Date of Last Mammogram: _____ **Infections History:** History of Syphilis : \square Yes \square No Positive T.B. Test in past: ☐ Yes ☐ No History of HIV: ☐ Yes ☐ No Live with someone with T.B.: ☐ Yes ☐ No Intercourse with person with HIV: ☐ Yes ☐ No Rash or Viral Illness: ☐ Yes ☐ No



History of Hepatitis:

Genital Herpes:

Other Infections:



☐ Yes ☐ No

☐ Yes ☐ No

Yes

Other STD:



☐ Yes ☐ No



Questions or concerns to the doctor/ Reason for:

onstitutional Symptoms			Neurological	
ever	☐ Yes	□ No	_	No
Chills	☐ Yes	\square No	Dizzy Spells ☐ Yes ☐ I	No
Weight Loss/Gain	☐ Yes	□ No	Numbness/Tingling Yes I	No
Allergic/Immunologic	1		Eyes	
ood Allergies	☐ Yes	□ No	Blurred Vision ☐ Yes ☐ I	No
Orug Allergies	□ Yes	□ No	Double Vision □ Yes □ I	No
Endocrine			Gastrointestinal	
Excessive Thirst	☐ Yes	□ No	Abdominal Pain 🗆 Yes 🗀 I	No
Γοο hot/cold	☐ Yes	□ No	Nausea/Vomiting ☐ Yes ☐ I	No
Fired/Sluggish	☐ Yes	□ No	Indigestion/heartburn □ Yes □] N
Cardiovascular	1		Integumentary (skin)	
Chest Pain	☐ Yes	□ No	Skin Rash ☐ Yes ☐ I	No
Blood Clotting Problem	□ Yes	□ No	Boils ☐ Yes ☐ I	No
Swelling Legs	☐ Yes	□ No	Persistent Itch Yes I	No
High/Low Blood Pressure	☐ Yes	□ No		
Respiratory			Psychologic	
Wheezing	☐ Yes	□ No	General Satisfaction with your life	
			□ Yes □ I	No
requent Cough	☐ Yes	□ No	Severe Depression $\ \ \Box$ Yes $\ \ \Box$ I	No
Shortness of Breath	☐ Yes	□ No	Considering Suicide ☐ Yes ☐ I	No
Breast			Genitourinary	
Breast Pain	☐ Yes	□ No	Urine Retention ☐ Yes ☐ I	No
Nipple Discharge	☐ Yes	□ No	Painful Urination \qed Yes \qed I	No
Breast Lumps	☐ Yes	□ No	Urinary Frequency ☐ Yes ☐ I	No



720 Alamitos Ave Long Beach, CA-90813





Tel: (562) 546-2496 Fax: (562) 546-2794