IMPERIAL CARE INTERNAL MEDICINE

Sumbul Islam, M.D.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME/NOMBRE: (Last, First, M.I)	Male or Female
DOB/ FECHA DE NACIMIENTO:	
MARITAL STATUS /ESTADO CIVIL: Single/Soltero Partnered/Con pareja Married/Casado Separated/Divorciado Widowed/Viudo	

HEALTH HISTORY/ HISTORIA MEDICA	
Childhood Illness/Enfermedades de la infancia: ☐ Measles/Sarampion ☐ Mumps ☐ Rubella/Rubeola ☐ Chickenpox/Varicela ☐ Rheumatic fever/ Fiebre reumatica ☐ Polio	
Immunizations and dates/ Inmunizaciones y fechas:	
☐ Tetanus/Tetanos:	☐ Pneumonia/Neumonia:
☐ Hepatitis:	☐ Chickenpox/Varicela:
☐ Influenza:	☐ MMR Measles, Mumps, Rubella:

MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED/ PROBLEMAS MEDICO QUE OTROS MEDICOS LO HAN DIAGNOSTICADO

SURGERIES / CIRUGIAS		
Year/Ano	Reason/Razon	Hospital

OTHER PROBLEMS/ OTROS PROBLEMAS		
___ Skin/Piel	___Chest/Heart/ pecho/Corazon	___Weight/ Peso
___Head/Neck Cabeza y cuello	___Back/ Espalda	___Energy level/ nivel de energia
___ Ears/ Oidos	___ Intestinal	___Ability to sleep/ Capacidad para dormir
___Nose/ Nariz	___Bowel/ Intestino	
___ Throat/ Garganta	___Bladder/ Vejiga	___ Other pain/discomfort/ otros dolores o molestias:
___Lungs/ Pulmones	___Circulation/ circulacaion	

PRESCRIBED DRUGS VITAMINS, AND OVER-THE-COUNTER DRUGS/ MEDICAMENTOS CON RECETA O DE VENTA LIBRES, VITAMINAS Y LOS INHALADORES		
Name the Drug/ Nombre de Medicina	Strength/Fuerza de medicina	Frequency Taken/ Seguido se toma

ALLERGIES TO MEDICATIONS/ ALERGIAS A MEDICAMENTOS	
Name of drug/ Nombre de medicina	Reaction you had/ Reaccion que tuvo

Preferred Pharmacy

Local Pharmacy/Farmacia Local: ______________________________

Mail Order/Orden de Correo: ______________________________

HEALTH HABITS AND PERSONAL SAFTEY/ HABITOS DE SALUD Y SEGURIDAD PERSONAL				
Alcohol	Do you drink alcohol?/ Toma alcohol?			YES NO
	If yes, what kind?/ Que tipo?			YES NO
	How many drinks per week?/ Cuantas bebidas por semana?			YES NO
	Are you concerned about the amount you drink?/ Esta preocupado por la cantidad que bebe?			YES NO
	Have you considered stopping? Ha pensado en parar de beber?			YES NO
	Have you ever experienced blackouts?/ ha tenido Perdida del conocimiento?			YES NO
	Are you prone to "binge" drining?/ Es usted propenso a la borrachera?			YES NO
	Do you drive after drinking?/ Maneja despues de tomar?			YES NO
Tobacco/Tabaco	Do you use tobacco/ Usa tabaco?			YES NO
	___ Cigarettes pks./day/ Cigarrillos-cuantos/dia	___Chew- #/day Masticar- cuanto/dia	___Pipe- #/day Pipa- cuanto/dia	___ Cigars- #/day Cigarros- cuanto/dia
	___ # of years/ # de anos de uso	___ Or year quit/ que ano dejo de usar tabaco?		
Drugs/Drogas	Do you currently use recreational or street drugs?/ Utiliza Drogas recreativas o de la calle?			YES NO
	Have you ever given yourself street drugs with a needle?/ Alguna vez te has dado Drogas de la calle con una aguja?			YES NO

MENTAL HEALTH/ SALUD MENTAL

MENTAL HEALTH/ SALUD MENTAL		
Is stress a major problem for you?/ Estres es problema para usted?	YES	NO
Do you feel depressed?/ Se siente deprimido?	YES	NO
Do you panic when stressed?/ entra en panico cuando esta estresado?	YES	NO
Do you have problems with eating or you appetite?/ tiene problemas con comer o apetito?	YES	NO
Do you cry frequently? Llora frequentemente?	YES	NO
Have you ever attempted suicide?/ Alguna ves ha intenado suicidarse?	YES	NO
Do you have trouble sleeping?/ Tiene dificultad para dormir?	YES	NO
Have you ever been to a counselor ?/ Aguna vez has visto a un consejero?	YES	NO

FAMILY HEALTH HISTORY/ HISTORIA DE FAMILIA

	AGE/EDAD	IF ANY HEALTH PROBLEMS / Problemas de salud
FATHER/PADRE		
MOTHER/MADRE		
SIBLINGS/ HERMANOS	Male Female_____	
	Male Female_____	
	Male Female_____	
CHILDREN/ HIJOS	Male Female_____	
	Male Female_____	
	Male Female_____	
GRANDMOTHER (MATERNAL/PATERNAL)		
GRANDFATHER (MATERNAL/PATERNAL		

PATIENT INFORMATION/ INFORMACION DE PACTIENTE

Ethnicity / Etnicidad- Race

__ Hispanic or Latino
__ White
__ American Indian/ Alaska Native
__ Asian/ Asiatico
__ Black or African American
__ Native Hawaiian
__Other

Primary language spoken/Primer idioma:		Secondary Language:
Address/ Direccion:		Phone number:
City/Ciudad:	State/ Estado:	Zip Code/ Codigo Postal:
Occupation/ Occupacion:	Employer/ Empleado:	

______CONSENT TO MEDICAL CARE AND TREATMENT I am being treated at ("Physician Office/Clinic"), and I consent to all medical and surgical care, examinations and test determined by my physician that are necessary for me. Though I except the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my physician's recommendations as they may relate to my health the physician and this office will not be responsible for any injuries or damages that are a result of my non-compliance. I understand that if an employee or any individual associated with the physician's office is exposed to my blood or body fluid, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will be charged for both testing and education related to the exposure

______CONSENT TO USE INFORMATION Electronic Health Records. I understand that the Physician Office may collaborate with other health care providers to coordinate, manage, and provide health care to me and I consent to the Physicians Office's sharing my health information and records electronically for the purpose of treatment, payment and/ or operations, including the over all quality health care services provided to me. I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The Physicians Office has implemented administrative, physical, and technical safeguards that reasonably and appropriate protect and confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my health information, I agree that the Physician Office may use and disclose my health information for a range of purposes including: treatment, eligibility, verification, and/or payment to private and public payers, including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Worker's Compensation programs, obtaining pre admission or continued length of stay certification, quality of care assessment and improving activities, evaluating the performance of qualifications of physicians and healthcare workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, adult services, ensuring compliance with legal, regulatory ad accreditations requirements and public health oversight services.

Request for Information from others. I consent to the Physicians Office request of my health information from other providers providing care to me, receipt of and release of my health information, whether written, verbal or electronic, for the uses described above as well as by Physicians Office participation in any health information exchange described in the Physician Office's Notice of Privacy Practices (NPP). Please refer to the NPP for Additional, detailed information regarding the uses and disclosures of protected health information.

______ ASSINGMENT OF BENEFITS I herby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician's Office for services provided to me. I understand that the benefits may be payable to me directly if I do not provide this authorization.

_____ FINANCAIL RESPONSIBILTY I understand and agree that I am financially responsible for payment of all charged incurred which are not paid by insurance of health care benefits, including any and all products provided and/or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by healthcare providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer.

______ PHARMACY BENEFITS MANAGERS I understand and agree that IMPERIAL CARE INTERNAL MEDICINE can request and use prescription medication history from other health care providers and/or third-party pharmacy benefit payors for treatment purposes.

______ PEROSONAL VALUABLES I understand that the Physician's Office does not accept responsibility for any lost, stolen, and/or damaged personal items while
I am at the Physician's Office.

______ OFFICE POLICIES As a patient of IMPERIAL CARE INTERNAL MEDICINE I understand payment is due at time services are rendered, unless prior payment arrangements re made with the office, this includes any deductible, copayment or co-insurance amount. Any balances not paid by my insurance carried are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand is my account if forwarded to a collection agency I may be dismissed from the practice; my outstanding balance may be reported to the credit bureau and my balance may be charged an 18% interest rate per year until balance is revolved. I am to present proof of my insurance coverage at ***EVERY*** office visit. **I UNDERSTAND IF I AM MORE THAN 15 MINUTES LATE FOR MY SCHEDULED APPOINMENT I MAY BE ASKED TO RCHEDULE APPOINTMENT I MAY BE ASKED TO RESHELDULE FOR ANOTHER DAY.** Finally, I understand that I am to allow at least 48 hours for my prescription refills.

RELEASE INFORMATION

I give my permission for the office staff to leave a message on my answering machine regarding:

___ Appointment reminders ___ Test results

___ Request for return phone call ___No answering machine available or permission not given

I give permission for the office staff to speak to: Name: ____________________________________

. Phone number: __________________________