Patricia G. Gao, M.D., LLC

Board Certified Internal Medicine

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LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

REFERRED BY: _____ SEX (M/F): _____ STATUS: _____ S M D W

BIRTHDAY: _____/_____/_____ SOCIAL SECURITY # _____-_____-_____

HOME PHONE: (_____) _____ -_____ WORK PHONE: (_____) _____-_____

CELLPHONE: (_____) _____-_____

EMAIL ADDRESS: _____EMAIL APPOINTMENT REMINDER (YES/NO)

EMERGENCY CONTACT:_____ CONTACT NUMBER: (_____) _____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
INSURED NAME: _____
RELATIONSHIP: _____ DOB: _____
COPAY AMOUNT: _____
POLICY NUMBER: _____
GROUP NUMBER: _____
EMPLOYER: _____

SECONDARY INSURANCE: _____
INSURED NAME: _____
RELATIONSHIP_____ DOB: _____
COPAY AMOUNT: _____
POLICY NUMBER: _____
GROUP NUMBER: _____
EMPLOYER: _____

GUARANTOR INFORMATION

GUARANTOR: _____ ADDRESS:
_____

CITY: _____STATE: _____ ZIPCODE: _____ TELEPHONE (_____) _____-
_____

PATIENT'S AUTHORIZATION

I authorize PATRICIA G. GAO, M.D.; LLC to apply for benefits on my behalf for services rendered by PATRICIA G. GAO, M.D., LLC. I request payment from my insurance company be made directly to PATRICIA G. GAO, M.D., LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims, I permit a copy of this authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

SIGNATURE OF SUBSCRIBER OR BENEFICIARY: _____

DATE: _____

FAMILY PRACTICE/INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE AND OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:
_____
Other concerns:
_____

ALLERGIES
List anything that you are allergic to (medications, food, bee stings, ect)

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACY & LOCATION

_____

MEDICATIONS
Please list all medications you are currently. Include prescribed drugs, over the counter, vitamins, ect.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IMMUNIZATION HISTORY

- Chicken pox Date: _____
- Flu shot Date: _____
- Gardasil/HPV Date: _____
- Hepatitis A Date: _____
- Hepatitis B Date: _____
- Zostavax (Shingles) Date: _____
- ☐ Meningococcus Date: _____
- ☐ MMR (measles/mumps/rubella) Date: _____
- ☐ Pneumonia Date: _____
- ☐ TDAP (tetanus/pertussis) Date: _____
- ☐ Tetanus Date: _____

(WOMEN ONLY) OB-GYN HISTORY

Last PAP smear Date _____ ☐ Abnormal ☐ Normal
Last mammogram Date_____ ☐ Abnormal ☐ Normal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
Miscarriages: _____ abortions: _____
☐ Cesarean sections If yes, how many: _____
☐ Bleeding between periods ☐ Painful Intercourse ☐ Extreme menstrual pain
☐ Heavy periods ☐ Birth control method ☐ Vaginal itching, burning, or discharge
☐ Hot flashes ☐ Breast lump or nipple discharge

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clots or (DVT)
- ☐ Cancer _____
- ☐ Coronary Artery disease (CAD)
- ☐ Claustrophobic
- ☐ Diabetes – Insulin
- ☐ Diabetes -- Non-insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ has Pacemaker
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Hiatal Hernia
- ☐ Esophageal Reflux (GERD)
- ☐ HIV or AIDS
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leg/foot ulcers
- ☐ Liver disease
- ☐ Hyper / Hypo Thyroid
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary embolism
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

FAMILY HEALTH HISTORY

	Mother	Father	Brother	Sister	Daughter	Son	Maternal GM	Paternal GM	Maternal GF	Paternal GF
Hypercholesterolemia										
Diabetes										
Hypertension										
Heart Disease										
Stroke										
Thyroid Disease										
Cancer										
Mood Disorder(Bipolar, Depression)										

SOCIAL HISTORY

Occupation
No

_____

Marital Status ☐ Married ☐ Single ☐ Divorced

_____

☐ Separated ☐ Widowed ☐ Domestic Partner
Number of children _____

☐ No
Sexually Active ☐ Yes ☐ No

_____
Current sexual partner ☐ Female ☐ Male
Do you use condoms? ☐ Yes ☐ No ☐ Other: _____
☐ Interested in being screened for STD's
> 3x week

Exercise Level ☐ None ☐ Occasional ☐ Moderate

Currently use Tobacco? ☐ Yes ☐ No **Former use?** ☐ Yes ☐

☐ Cigarettes - _____ pks/day ☐ Chew- _____/day
☐ Cigars- _____/day ☐ # of years use _____ Year quit

Drugs: Do you currently use recreational or street drugs? ☐ Yes

If yes, list:

Alcohol: Do you drink alcohol? ☐ Yes ☐ No
If so, how often? ☐ Occasional ☐ < 3x week ☐

Caffiene: ☐ None ☐ Occational ☐ Moderate ☐ Heavy

☐ High level # of cups/cans per day? _____

REVIEW OF SYSTEMS Please check all that apply:

Allergic/ Immunologic
- ☐ Frequent sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny nose
- ☐ Sinus pressure

Cardiovascular
- ☐ Arm pain on Exertion
- ☐ Chest pain on Exertion
- ☐ Chest heaviness/ pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Light-headed on standing
- ☐ Shortness of breath when walking
- ☐ Shortness of breath when lying down
- ☐ Swelling (edema)
- ☐ Known heart murmur

Constitutional
- ☐ Exercise intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain (_____lbs)
- ☐ Weight loss (_____lbs)

Eyes
- ☐ Dry eyes
- ☐ Irritation
- ☐ Vision change

Date of last exam: _____

Psychiatric
- ☐ Alcohol overuse
- ☐ Anxiety/ stress
- ☐ Depression
- ☐ Do not feel safe in relationship
- ☐ Mania
- ☐ Sleep problems

Ear/Nose/Throat/Mouth
- ☐ Bleeding gums
- ☐ Difficulty hearing
- ☐ Dizziness
- ☐ Dry mouth
- ☐ Ear pain
- ☐ Frequent infections
- ☐ Frequent nosebleeds
- ☐ Hoarseness
- ☐ Mouth breathing
- ☐ Mouth ulcers
- ☐ Nose/Sinus problems
- ☐ Ringing in ears

Endocrine
- ☐ Fatigue
- ☐ Increased thirst/hunger/urination

Gastrointestinal
- ☐ Abdominal pain
- ☐ Black/ tarry stool
- ☐ Blood in stool
- ☐ Change in appetite
- ☐ Frequent indigestion
- ☐ Hemorrhoids
- ☐ Trouble swallowing
- ☐ Vomiting
- ☐ Vomiting blood

Respiratory
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Wheezing

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Incomplete Emptying
- ☐ Increased urinary frequency
- ☐ Urinary loss of control

Hematologic/Lymphatic
- ☐ Change in moles
- ☐ Dry skin
- ☐ Eczema
- ☐ Growth/lesions
- ☐ Itching
- ☐ Jaundice (Yellow skin/ Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Muscle weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless legs
- ☐ Seizures
- ☐ Weakness

Please add any other information about your health that you would like your provider to know here:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
_____

Parent, Gaurdian, or Caregiver Signature **Date**