THOMAS W. HOPKINS, M.D.

2235 Douglas Blvd, Ste. 510
Roseville, CA 95661
(916) 446-4449

PATIENT_____BIRTHDATE_____ AGE_____ SEX: M or F
(LAST) (FIRST) (MI)

MAILING ADDRESS_____ZIP CODE_____

RESIDENCE ADDRESS (IF DIFFERENT)_____ZIP CODE_____
(STREET) (CITY)

SOCIAL SECURITY #_____ EMPLOYER_____

HOME PHONE (____) _____WORK PHONE (____) _____ EMAIL_____

PREFERRED METHOD OF CONTACT: ___MY HEALTH ONLINE ___MAIL ___EMAIL ___HOME PHONE ___CELL PHONE

EMERGENCY CONTACT NAME AND PHONE # _____

MARTIAL STATUS: ___SINGLE ___MARRIED ___DIVORCED ___WIDOWED

SPOUSE'S NAME_____ SPOUSE'S BIRTHDATE_____

REFERRING PHYSICIAN_____ TELEPHONE (____)_____

PLEASE PROVIDE INFORMATION IF YOU WOULD LIKE US TO BILL YOUR HEALTH INSURANCE:

NAME OF PRIMARY INSURANCE:_____

SECONDARY INSURANCE:_____

NAME OF INSURED PERSON:_____ID#:_____GRP#:_____

ADDRESS OF MEDICAL INSURANCE:_____

*INSURED DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

I VERIFY THAT THE INFORMATION ABOVE IS CORRECT. I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF DR. HOPKINS'S APPOINTMENT POLICY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY MY MEDICAL INSURANCE. I WILL ALSO BE RESPONSIBLE FOR ANY COSTS OF COLLECTION OR ATTORNEYS FEES IN THE EVENT THAT THEY ARE NECESSARY. I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION NECESSARY TO SECURE PAYMENTS FROM MY MEDICAL INSURANCE CARRIER. I ALSO AUTHORIZE MY INSURANCE CARRIER BY MY SIGNATURE BELOW TO PAY ANY MEDICAL BENEFITS DIRECTLY TO DR. THOMAS HOPKINS.

DATE_____ SIGNATURE_____
Patient or Responsible Party, if minor

2025 P Street
Sacramento, CA 95814
916-446-4449

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

In accordance with Federal privacy rules implemented through the Healthcare Portability and Accountability Act of 1996: With my consent, THOMAS W. HOPKINS, M.D., hereafter referred to as the "Practice", may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to THOMAS W. HOPKINS, M.D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practice prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

THOMAS W. HOPKINS, M.D.
ATTN: PRIVACY OFFICER
2025 P Street
Sacramento, CA 95814

With my consent, the Practice may call my home, cell phone or other designated location and leave a message on voice mail and in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including lab results. With my consent, the Practice, may e-mail or mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards marked Personal and Confidential and statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to the Practice's use of disclosure of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, THOMAS W. HOPKINS, M.D. may decline to provide treatment to me.

In order for your physician or staff or the Practice to discuss your conditions with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **DO NOT** authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

_____ I **DO** authorize the practice to verbally release any or all information concerning my medical care and/or billing issues to the following individual(s):

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

_____ _____
Patient Signature Date

HEALTH QUESTIONNAIRE

NAME: _____
LAST FIRST MIDDLE

Date of Birth: _____

Preferred Pharmacy: _____ Phone: _____

Mail Order Pharmacy □ Yes □ No Pharmacy Name: _____

Address: _____

Phone: _____

1. Do you have any **ALLERGIES** to medications? (List medication and describe the reaction)_____
_____

2. List any **MEDICATIONS** that you are currently taking below **(including vitamins, herbs or over the counter medication):**

Medication	Strength	Times Per Day	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

3. Do you currently SMOKE or use TOBACCO PRODUCTS? Have you ever SMOKED or USE TOBACCO PRODUCTS? (How much, how long?)
_____

4. Do you DRINK ALCOHOL? (How much per week)_____

5. Do you currently use recreational or medical marijuana? _____

6. Do you have a history of illicit drug use or abuse? (When? How long?)
_____

7. Are you sexually active?_____ Partner Preference: ___Male ___Female

8. Last normal menses: _____ Age at onset of menses:_____

9. Do you currently have any medical issues? (Example: Diabetes, Hypertension)

- _____
- _____
- _____

10. Have you had any **SURGERIES**? (Example: Tonsillectomy, Hysterectomy)

Date **Type of Surgery**

1._____
_____
2. _____
_____
3. _____
_____

11. Have you ever been **HOSPITALIZED** besides for surgery? _____

12. What Diseases/Conditions have affected your family? (Example: Diabetes, Cancer, Heart Disease)._____

FAMILY MEMBER **HEALTH PROBLEMS**

Mother: ALIVE___DECEASED___ AGE___
MEDICAL PROBLEMS:_____
_____

Father: ALIVE___DECEASED___ AGE___
MEDICAL PROBLEMS:_____
_____

Sister(s): ALIVE___DECEASED___ AGE___
MEDICAL PROBLEMS:_____
_____

Brother(s):ALIVE___DECEASED___ AGE___
MEDICAL PROBLEMS:_____
_____

Grandparents: ALIVE___DECEASED___ AGE___
MEDICAL PROBLEMS:_____
_____

13. Do you have any **CHILDREN**? (What are their ages?)

_____

14. How much do you **EXERCISE**?

_____

15. How are your **NUTRITIONAL** habits? (Examples: poor, fair, good or excellent)

_____

WEIGHT HISTORY QUESTIONS:

a) Do you struggle trying to maintain a healthy body weight? _____
b) Are you comfortable at your current weight? _____
c) What was your weight when you were 18 years old? _____
d) What was your maximum weight? (What year)_____
e) What was your lowest weight after age 20? _____
f) At what weight do you feel most healthy? _____
g) What METHODS have you used to assist you in achieving a healthier weight? (Examples: Weight Watchers, Medications, Fad diets, etc.)_____
_____

METHOD	YEAR	HOW LONG?	HOW MUCH LOST/GAINED?
1.			
2.			
3.			
4.			
5.			
6.			
7.			

h) What is a realistic **GOAL WEIGHT** for you? _____

i) Why is achieving this **GOAL** important to you?_____
_____

16. REVIEW OF SYSTEMS QUESTIONNAIRE:

Please **CIRCLE** any of the following symptoms **ONLY IF YOU ARE BEING AFFECTED BY ANY OF THE SYMPTOMS NOW:**

GENERAL: Weakness, fatigue, fever, chills, sweats, sleep disorder, unexplained weight loss.

EYES: Loss of vision (one or both eyes), double vision, eye irritation or pain, blurred vision, spots in vision (halos), discharge, light sensitivity.

ENT:
EARS: Earache, drainage, hearing loss, ringing in the ears.
NOSE: Congestion, bleeding, postnasal drainage, sneezing, abnormal sense of smell.

THROAT: Sore throat, difficulty swallowing, hoarseness.
MOUTH: Soreness, sores, bleeding gums, tooth or jaw pain, difficulty chewing.

CARDIOVASCULAR:
HEART: Chest pain or discomfort, racing/skipping beats, shortness of breath with exertion or lying flat, fainting/near fainting, leg cramps with exertion, weight gain, swelling of hands/feet.

RESPIRATORY:
LUNGS: Sleep disturbances due to breathing, cough, shortness of breath, coughing up blood, chest pain when breathing deeply, coughing up blood, wheezing, excessive snoring.

GASTROINTESTINAL:
ABDOMEN: Pain, gas, bloating, cramping, heartburn, diarrhea, constipation, blood with bowel movements, loss of bowel control, loss of appetite, rectal bleeding, hemorrhoids.

GENITOURINARY:
URINARY: Blood in urine, frequency, urgency, difficulty urinating, discoloration of urine, loss of control, painful urination, sleep disrupted by urge to urinate.
GENITALS: Pain, swelling, masses, discharge, bleeding, skin lesions, sexual dysfunction?
MENSTRUAL: Heavy blood flow during menses, cramping, mood swings, or missed menstrual cycles.

MUSCULOSKELETAL:
EXTREMITIES: Joint pain, swelling, back pain, stiffness, muscle weakness, loss of strength, muscle aches/cramps, gout.

DERMATOLOGIC:
SKIN: Suspicious lesions, dryness, poor wound healing, skin cancer, itching, changes in skin color, rash, bleeding, bruising.

NEUROLOGIC:
CNS: Difficulty w/concentration, poor balance, headaches, disturbances in coordination, numbness/tingling, seizures, weakness, sensation of room spinning, tremors, memory loss.

PSYCHOLOGICAL:
PSYCH: Sense of great danger, anxiety, thoughts of suicide/homicide, depression, thoughts of violence, hallucinations, physical/sexual abuse, psychological trauma, mental instability.
Have you been hospitalized or sought counseling? Do you have a history of violence?

IMMUNIZATIONS:
Have you been vaccinated for the following? Circle all that apply, indicate year:
Measles:_____ Mumps:_____ Rubella:_____ Rubeola:_____ Polio:_____
Diphtheria:_____ Pertussis:_____ Tetanus:_____ Hepatitis A:_____ Hepatitis B:_____
Influenza:_____

Advanced Directive Information

You may unexpectedly be in a position where you cannot speak for yourself - such as an accident or severe illness - and be unable to make treatment decisions. If this happens, you want to be assured that appropriate decisions are made. You can define in advance what medical treatment you prefer.

An Advance Health Care Directive (AHCD) lets you say what you want and who you want to speak for you. An AHCD allows you to appoint an agent who has power of attorney to make care and treatment decisions on your behalf, and give instructions about your health care wishes.

Who should get copies of the completed form?
Copies of the completed form should be given to each person named as agent, or proxy, and to your primary care physician so that it may be added to your medical record.