Patient Health Questionnaire

NAME: _____ DATE: _____

WHAT IS THE NATURE OF THE PROBLEM FOR WHICH YOU ARE SEEING THE DOCTOR: _____

_____

OCCUPATION (IF RETIRED, YOUR FORMER OCCUPATION): _____

MEDICATIONS: PLEASE LIST ALL MEDS, INCLUDING DOSAGE AND FREQUENCY AS WELL AS OVER THE COUNTER MEDS SUCH AS ASPIRIN, TUMS, VITAMINS, ETC.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS, OR ARE THERE ANY MEDICATIONS YOU CANNOT TAKE? PLEASE LIST THEM BELOW.

1. _____ 2. _____

ANY FOOD ALLERGIES? PLEASE LIST THEM BELOW.

1. _____ 2. _____

HABITS AND SYMPTONS: PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO.

1. DO YOU HAVE HEADACHES, TROUBLE WITH YOUR EYES, EARS, NOSE OR THROAT? YES OR NO
2. DO YOU SMOKE? YES OR NO FORMER OR NEVER HOW MUCH? _____ PACKS PER DAY.
3. DO YOU HAVE A COUGH? YES OR NO DO YOU HAVE CHEST DISCOMFORT? YES OR NO
4. HAVE YOU EXPERIENCED WEIGHT LOSS? YES OR NO IF YES, HOW MUCH? _____
5. HAVE YOU EXPERIENCED A CHANGE IN YOUR APPETITE? YES OR NO
6. DO YOU HAVE A HISTORY OF HEART ATTACK OR OTHER HEART DISEASE? YES OR NO
7. DO YOU HAVE HIGH BLOOD PRESSURE? YES OR NO DO YOU HAVE ANGINA? YES OR NO
8. DO YOU HAVE A HISTORY OF ULCERS, HEPATITIS (LIVER DISEASE), DISEASE OF THE BOWERLS OR COLON, CONSTIPATION, DIARRHEA OR CHANGING BOWEL HABIT? YES OR NO IF YES,PLEASE EXPLAIN: _____
9. HAVE YOU EVER FAINTED? YES OR NO DO YOU HAVE HISTORY OF CONVULSIONS, STROKE, PARALYSIS, OR WEAKNESS? YES OR NO IF YES, PLEASE SPECIFY: _____

   _____
10. DO YOU HAVE A HISTROY OF DIABETES? YES OR NO IF YES, HOW LONG? _____
11. ARE YOU SLEEPING WELL? YES OR NO IF NO, PLEASE SPECIFY: _____

    _____
12. ALCOHOL INTAKE? DRINKS PER DAY/WEEK: _____

    CAFFIENE INTAKE? (COFFEE, TEA, COLA) DRINKS PER DAY/WEEK: _____

13. DO YOU HAVE A HEARING AID, PACE MAKER, OR ANY PROSTHETIC DEVICE? YES OR NO
14. DO YOU HAVE ANY OTHER HABITS AND/OR SYMPTONS NOT COVERED BY THIS QUESTIONNAIRE? YES OR NO IF YES, PLEASE SPECIFY: _____
15. DO YOU HAVE A LIVING WILL OR DURABLE MEDICAL POWER OF ATTORNEY? IF SO, MAY WE HAVE A COPY? YES OR NO
16. WHO IS YOUR PRIMARY CARE PHYSICIAN OR GENERAL MEDICAL CARE PROVIDER? NAME & ADDRESS: _____

FAMILY HISTORY: ARE THERE ANY ILLNESSES THAT RUN IN YOUR FAMILY? PLEASE CIRCLE THOSE THAT ARE FOUND IN YOUR BLOOD RELATED FAMILY MEMBERS:

DIABETES CANCER GOUT THYROID DISEASE HEART DISEASE

OTHERS (PLEASE LIST): _____

PREVIOUS SURGEREY: HAVE YOU HAD ANY OPERATIONS IN THE PAST? YES OR NO IF YES, PLEASE CIRCLE/LIST ALL OPERATIONS AND INDICATES APPROXIMATE DATES.

GALLBLADER _____ THYROID _____

HYSTERECTOMY _____ HERNIA _____

OTHER _____

HOSPITALIZATIONS OTHER THAN SURGERY: PLEASE LIST REASONS AND APPROXIMATE DATES:_____

_____

FOR WOMEN: HOW MANY PREGNANCIES HAVE YOU HAD? _____

HOW MANY DELIVERIES? _____ HOW MANY C-SECTIONS? _____

ARE YOU HAVING REGULAR PERIODS? YES OR NO IF NOT, WHEN DID THEY STOP? _____

FOR PATIENTS WITH DIABETES: DO YOU TEST YOUR BLOOD SUGARS AT HOME? YES OR NO IF YES, WHAT METHOD OR MACHINE DO YOU USE? _____

DO YOU TEST YOUR URINE AT HOME FOR SUGAR OR KETONES? YES OR NO

ARE YOU ON A SPECIAL DIET? YES OR NO

DO YOU EXERCISE REGULARLY? YES OR NO IF YES, WHAT KIND OF EXERCISE? _____

MISCELLANEOUS: IF THERE IS ANYTHING ELSE YOU THINK WOULD BE HELPFUL FOR DR. Sethi to Know ABOUT, PLEASE LIST HERE: _____

_____

_____

_____

_____

_____

ARIZONA COMMUNITY PHYSICIANS
REGISTRATION ADDENDUM

Patient Name:_____

Account Number:_____

Due to a governmental mandate that all healthcare is provided fairly, without regard to race or ethnicity, we have added new fields to our patient registration form. This information will be kept confidential.

Race (check one)

☐ Black, African American (01)

☐ Asian (02)

☐ Caucasian (White) (03)

☐ American Indian, Alaskan Native (08)

☐ Native Hawaiian/Other Pacific Islander (09)

☐ Unknown (98)

☐ Declined (99)

Ethnicity (check one)

☐ Hispanic or Latino

☐ Not- Hispanic or Latino

☐ Unknown

E-mail (optional)

_____

_____

Patient Signature

_____

Parent/Guardian Signature

Preferred Language (check one)

☐ English (EN)

☐ Spanish (ES)

☐ Arabic (AR)

☐ Chinese (all types) (ZH)

☐ French (FR)

☐ German (DE)

☐ Greek (EL)

☐ Italian (IT)

☐ Japanese (JA)

☐ Korean (KO)

☐ Navajo (NV)

☐ Polish (PL)

☐ Russian (RU)

☐ Tagalog' (TL)

☐ Ukrainian (UK)

☐ Vietnamese (VI)

☐ Other_____
(Specify)

☐_____

Patient declined filing out the form. Staff signature required

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WESTERN ENDOCRINE ASSOCIATES

A member of Arizona Community Physicians Family

www.azacp.com

No Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

A patient who does NOT SHOW for their appointments, and who does not notify the practice in advance, will be charged an administrative fee of $25.00. The fee is not payable by any insurance company, and remains the responsibility of the patient. This is due in full prior to your next appointment. We ask that you please call in 24 hours in advance if you are unable to keep your appointment. We do make courtesy reminder calls to patients, so please make sure we have current contact information for you.

Multiple no shows or cancelled visits may result in being dismissed from our practice for non-compliance.

Form Completion Fees

There is an administrative fee charged for form completion requests. Our fees start at $25.00 and up. The amount of time spent researching and completing the form dictates the actual cost. If you would like a quote prior to having the form completed, please let us know. This fee is not covered by insurance companies.

Medications

Our physicians will only authorize prescription refills that they have prescribed. Your refill requests may be denied if you do not keep your follow up appointments. If you have any questions regarding this policy, please discuss this with your doctor at today's appointment.

If you need a refill on your medication, please contact your pharmacy directly. We recommend you contact them at least 72 hours in advance to allow time for our staff to review and approve these requests.

Office Charge

If you do not have insurance, payment is expected at time of service.

If you have insurance, we will submit your charges to your insurance company. Since insurance companies will not guarantee us payment, we cannot guarantee that your charges will be covered. The term "covered" means your insurance company will process the charge according to you benefits. You will be responsible for any out of pocket such as co-insurance or deductibles. Please check with your insurance company if you have questions about your coverage.

Failure to keep your account in good standing may result in you being dismissed from our practice.

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Lab Charges

If we are contracted with your insurance carrier, we will send your lab specimens to our facility. Sometimes it is necessary to send some tests that our lab does not perform to an outside lab. You may receive a separate billing from them if your insurance does not completely cover the test being performed. Some insurance negotiate coverage terms with employers and patients directly, and this can affect what you have to pay out of pocket. This can include sending you to another facility to get your labs drawn. Please make our staff aware of these terms at the check in window. Our staff is not made aware of these exceptions by the insurance company. It is the responsibility of the patient to inform us of any special insurance requirements.
I have read and acknowledged the above information.

Patient Signature

Date

Arizona Community Physicians, P.C.

Release of Information Form 02/15/2012

Patient Name _____ DOB _____ Date _____

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which a family member or close friend needs access to your health information, or to the health information of someone under your care.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records, or to your dependents medical records. This information is not limited to but includes appointments, billing information and test results.

Spouse's Name _____ Contact Number _____

Child's Name _____ Contact Number _____

_____ Contact Number _____

Parent's Name _____ Contact Number _____

_____ Contact Number _____

Other's Name _____ Contact Number _____

_____ Contact Number _____

DO NOT RELEASE Information to the following people: _____

_____

Please check if applicable:

_____ I give permission for my child (of >15 years old) to be seen without the presence of an adult.

_____ I give permission for my child (of >15 years old) to have minor procedures or immunizations without the presence of an adult.

_____ I give permission for my child to be taken to medical appointments by: _____

_____

Patient/Parent/Guardian Contact Numbers: Home_____ Work_____ Other_____

Signature of the Patient or their Parent/Legal Guardian _____

Form #116

Name: _____ Date: _____

REVIEW OF SYSTEMS

PLEASE MARK BOX IF YOU HAVE ANY PERTINENT, ONGOING, OR RECENT PROBLEMS WITH THE FOLLOWING:

CONSTITUTIONAL SYMPTOMS

□ Good general health lately

□ Recent weight change - How much? _____

□ Fever

□ Fatigue

EARS/NOSE/MOUTH/THROAT

□ Sore Throat or Voice Change

□ Swollen glands in neck

EYES

□ Eye disease or injury

□ Wear glasses or contacts

□ Blurred or double vision

CARDIOVASCULAR

□ Chest pain

□ Palpitations

□ Swelling of feet, ankles or hands

GASTROINTESTINAL

□ Loss of appetite

□ Change in bowel movements

□ Nausea or vomiting

□ Frequent diarrhea

□ Painful bowel movements or constipation

□ Rectal bleeding or blood in stool

□ Abdominal pain or heartburn

MUSCULOSKELETAL

□ Joint pain or stiffness

□ Weakness of muscles or joints

□ Muscle pain or cramps

□ Cold extremities

INTEGUMENTARY (skin, breast)

□ Rash, itching or dryness

□ Change in skin color

□ Varicose veins

□ Breast pain/lump

□ Night Sweats

□ Feet (change in toenail color)

□ Feet (change in toenail color)

NEUROLOGICAL

□ Frequent or recurring headaches

□ Light headed or dizzy

□ Numbness or tingling sensations

□ Tremors or shakes

□ Paralysis

□ Head Injury

PSYCHIATRIC

□ Memory Loss

□ confusion

□ Nervousness

□ Insomnia

□ Depression/□ Anxiety

RESPIRATORY

□ Chronic or frequent cough

□ Shortness of Breath

□ Asthma

ENDOCRINE

□ Glandular/hormone problem

□ Excessive thirst or urination

□ Heat or Cold Intolerance

HEMATOLOGIC/LYMPHATIC

□ Slow to heal after cuts

□ Bleeding or bruising tendency

□ Phlebitis

□ Enlarged or swollen glands

ALLERGIC/IMMUNOLOGIC

□ History or skin reaction or other adverse reaction to:

□ Penicillin or other antibiotics

□ Morphine, Demerol, or other narcotic

□ Novocain or other anesthetic

□ Aspirin or other pain remedies

□ Tetanus antitoxin or other serums

□ Iodine, methiolate or other antiseptic

□ Other – Please List _____

_____

Any other symptoms or concerns not covered? _____

_____

Patient Signature _____ Date_____

Physician Signature _____ Date_____