1 Country Club Plaza, Orinda, CA 94563
Ph: 925-254-3805 Fax: 925-254-9783

Name (Last, First, M.I.):_________________________________ Date:_______________________

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children:____________ Living:_________ Deceased: __________

Occupation is/was: ____

Previous or referring doctor: ____________________________________

Date of last physical exam: ______________________________________

HEALTH HISTORY QUESTIONNAIRE

Please complete this entire questionnaire. It will provide your care team with important information about your health.

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

Please indicate if YOU have a history of the following:

☐ Alcohol Abuse	☐ Anemia	☐ Anesthetic Complication	☐ Anxiety Disorder
☐ Arthritis	☐ Asthma	☐ Autoimmune Problems	☐ Birth Defects
☐ Bladder Problems	☐ Bleeding Disease	☐ Blood Clots	☐ Bowel Disease
☐ Breast Cancer	☐ Cervical Cancer	☐ Colon Cancer	☐ Depression
☐ Diabetes	☐ High Blood Pressure	☐ Migraines	☐ Osteoporosis
☐ Prostate Cancer	☐ Reflux/GERD	☐ Seizures/Convulsions	☐ Severe Allergy
☐ Sexually Transmitted Disease		☐ Skin Cancer	☐ Stroke/TIA
☐ Suicide Attempt	☐ Thyroid Problems	☐ Ulcer	☐ Visual Impairment
☐ Other Disease, Cancer, or Significant Medical Illness			☐ NONE of the Above

____

Childhood Illness:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox

☐ Rheumatic Fever ☐ Polio ☐ None

Immunizations and Dates:

☐ Tetanus__________ ☐ Pneumonia__________ ☐ Shingles__________ ☐ Hepatitis B__________

☐ Influenza_________ ☐ MMR Measles, Mumps, Rubella_________ ☐ Covid _________

Tests/Screenings Dates:

☐ Colonoscopy___________ ☐ DEXA bone scan_____________ ☐ AAA Screening___________

☐ PAP___________________ ☐ Mammogram ________________ ☐ CT Lung Screening________

Past Surgeries:

Year_________________ Reason____

Year_________________ Reason____

Year_________________ Reason____

Year_________________ Reason____

☐ I have had no surgeries

Other hospitalizations:

Year_________________ Reason____
Hospital___________________________________

Year_________________ Reason____
Hospital___________________________________

Year_________________ Reason____
Hospital___________________________________

Year_________________ Reason____
Hospital___________________________________

☐ I have never been hospitalized

Family Medical History:

Please indicate if YOUR FAMILY has a history of the following: (ONLY include parents, grandparents, siblings, and children)

☐ I am adopted and do not know biological family history

☐ Family History Unknown

☐ Alcohol Abuse	☐ Anemia	☐ Anesthetic Complication	☐ Anxiety Disorder
☐ Arthritis	☐ Asthma	☐ Autoimmune Problems	☐ Birth Defects
☐ Bladder Problems	☐ Bleeding Disease	☐ Blood Clots	☐ Bowel Disease
☐ Breast Cancer	☐ Cervical Cancer	☐ Colon Cancer	☐ Depression
☐ Diabetes	☐ Hypertension	☐ Migraines	☐ Osteoporosis
☐ Prostate Cancer	☐ Reflux/GERD	☐ Seizures/Convulsions	☐ Severe Allergy
☐ Sexually Transmitted Disease		☐ Skin Cancer	☐ Stroke/TIA
☐ Suicide Attempt	☐ Thyroid Problems	☐ Ulcer	☐ Visual Impairment
☐ Other Disease, Cancer, or Significant Medical Illness			☐ NONE of the Above

____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Drug ___________________________ Dose/Frequency__________ Drug___________________________ Dose/Frequency _____________

Drug ___________________________ Dose/Frequency__________ Drug___________________________ Dose/Frequency _____________

Drug ___________________________ Dose/Frequency__________ Drug___________________________ Dose/Frequency _____________

Drug ___________________________ Dose/Frequency__________ Drug___________________________ Dose/Frequency _____________

☐ List additional drugs on back of questionnaire

☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

Allergies:

Name ____________________________ Reaction________________________________

Name ____________________________ Reaction________________________________

Name ____________________________ Reaction________________________________

Name ____________________________ Reaction________________________________

☐ I have no known drug allergies

Social History:

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise: ☐ Yes ☐ No

If yes, how many minutes per week?___________________________

Diet Are you dieting? ☐ Yes, ______________________________ ☐ No

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola

# of cups/cans per day?_____________

Alcohol: ☐ Yes ☐ No

If yes, what kind?________________________ How many drinks per week?_____________

Tobacco:

☐ Current: cigarettes or cigars; ___________pks/day for ______________ years

☐ Former, year quit:___________ ☐ Never

Drugs: Do you currently use recreational or street drugs? ☐ Y:_____________ ☐ N

Please circle any symptoms you are currently experiencing or symptoms you have frequently experienced:

Fever	Easy bleeding or bruising	Muscle pain
Chills	Feeling poorly	Swelling in legs
Eye pain	Feeling tired/fatigued	Difficulty breathing while lying down/sleeping
Red eyes	Eyesight problems	Heartburn
Earache	Discharge from eyes	Black, tarry stools
Loss of hearing	Nosebleeds	Limb pain
Chest pain	Discharge from nose	Limb weakness
Palpitations	Fast/slow heartbeat	Difficulty walking
Shortness of breath	Cold hands/feet	Change in personality
Wheezing	Cough	Emotional problems
Abdominal pain	Shortness of breath with activity	Deepening of voice
Vomiting	Constipation	Vision changes
Pain with urination	Diarrhea	Ringing in ears
Urinary incontinence	Frequent urination at night	Sinus problems
Muscle/joint pain	Joint swelling	History of heart murmur
Skin lesions	Joint stiffness	History of heart attack
Skin wound	Itching	Coughing up phlegm/blood
Confusion	Change in mole	Blood per rectum
Convulsions/seizures	Dizziness	Urinary frequency
Suicidal	Fainting	Back pain
Sleep disturbances	Anxiety	Nail discoloration/deformity
Decreased libido/sexual desire	Depression	Numbness/tingling
Dry eyes	Swollen glands	Frequent falls
Eyes itch	Recent weight gain	Hair loss
Sore throat	Recent weight loss	
Hoarseness		

Other symptoms:

Signature of Patient or Legal Representative Date

ORINDA MEDICAL GROUP

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Ph: 925-254-3805 Fax: 925-254-9783

Biran J. Candell, M.D., Shawn D. Rosen, M.D, Yenjean S Hwang, M.D, Jessica Tsuei, M.D.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME: ____

I understand that as part of my healthcare, Whiting & Whiting originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses , treatment and any plans for future care for treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A course of information for applying my diagnosis and surgical information to my bill.
- A means by which third payer can verify that services billed were provided.
- A means by which call and leave a message regarding appointment reminders, insurance items, and any call pertaining to your clinical care, including laboratory results at the physician discretion.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment payment or health care operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the practice has already made disclosure in the reliance upon my prior consent. I fi do not sign this consent, Whiting & Whiting may decline to provide treatment to me.

I request the following restrictions to the use or disclosure of my health information:

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Signature of Patient or Legal Representative Date