Hillcrest Internal Medicine
4060 Fourth Avenue, Suite 505
San Diego, CA 92103
619 298-1318

HEALTH QUESTIONNAIRE

DATE:_____

NAME		AGE	DATE OF BIRTH
STREET ADDRESS	CITY	ZIP	TELEPHONE

HISTORY OF PAST ILLNESS: (Please list prior medical problems requiring treatment, or hospitalization)

CHILDHOOD DISEASES: (Circle if you have had this illness)

Measles	Diabetes
Mumps	Cancer
Chicken Pox	Rheumatic Heart Disease
Tubercolosis	Congenital Abnormalities

PAST SURGERIES AND YEAR OF SURGERY:

CURRENT MEDICATIONS

NAME /DOSE/ HOW OFTEN:

ALLERGIES TO MEDICATIONS

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SOCIAL HISTORY

Marital Status: _____ Number of Children_____

Current/Prior Occupation:_____ Is Sex Life satisfactory? _____

Do you have dependents at home?:_____ More than one sexual partner?_____

What is your sexual orientation? ☐ Heterosexual ☐ Homosexual

Tobacco Use: ☐Never or ☐ ____ Packs a day since what age? _____

Alcoholic Beverage Use: How many drinks per week? _____

FAMILY HISTORY

Family	Alive at Age or	Deceased at Age	Health Problems
Father			
Mother			
Siblings			
Children			
Other Family			

Circle the diseases below if any blood relative has had:

Cancer Tuberculosis Diabetes Heart Trouble High blood pressure

Stroke Bleeding Tendency Insanity

SYSTEMIC REVIEW: (Please circle any of the following that relate to you)

General:
- Recent weight change
- Insomnia

Head/Eye/Ears/ Nose/Throat:
- Headaches
- Dry Eyes
- Wear Glasses
- Bloody Nose
- Ringing in Ears
- Poor Hearing
- Sinus Trouble
- Runny Nose
- Sore Throat

Skin:
- Eczema
- Rash/Abnormal lesion
- Yellowing of skin

Neck:
- Thyroid Trouble
- Mass or Nodule in neck
- Stiffness

Respiratory:
- Cold symptoms
- Shortness of breath
- Asthma
- Wheezing
- Cough

Musculoskeletal:
- Back pain
- Varicose Veins
- Pain in legs with walking

Cardiovascular:
- Palpitations
- Chest Pain
- Shortness of breath with exertion
- Shortness of breath when lying flat
- Heart Murmur
- Swelling in hands or feet

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Gastrointestinal:

- Diarrhea
- Constipation
- Acid Relfux/Heart Burn
- Bloody or black stools
- Abdominal Cramping
- Hemorrhoids

Hematologic:

- Bleed easily
- Anemia
- Phlebitis
- Bruise easily

Genitourinary:

- Frequent urination
- Night time urination
- Burning/painful urination
- Discolored urine
- Urine Incontinence (Loss of control)
- Kidney Stone

Neurological:

- Paralysis
- Convulsions/Seizures
- Psychiatric Illness

Endocrine

- Thyroid Disease
- Hormone Therapy
- Hair growth changes
- You get colder easily

Gynecologic:
(FEMALES):
Age menses (period) began_____
How many days does it last?_____
How many days apart are they?_____

Number of pregnancies_____
Number of miscarriages_____
Number of live births____
Last Pap Smear_____
Last Menstrual Period_____
Last Mammo_____

Health Maintenance:
Last Colonoscopy:
Bone Density:
Tetanus:

Your Height_____
Your Weight_____

Source of Information, if other than the patient:_____

Signature of person acquiring this information X_____

Doctor Signature X_____

Signature of Patient X_____

NAME: _____
LAST FIRST MI

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME ADDRESS: ☐ SAME ☐ OTHER: _____

PRIMARY PHONE: _____ SEX: M F BIRTHDATE: _____

SECONDARY PHONE: _____ EMAIL: _____

SOCIAL SECURITY #: _____ DRIVER LICENSE #: _____

EMPLOYER / RETIRED: _____ WORK PHONE: _____

RACE: _____ ETHNICITY: _____ PRIMARY LANGUAGE: _____

EMERGENCY CONTACT: _____

PHONE: _____ RELATIONSHIP TO PATIENT: _____

PRIMARY INSURANCE: _____

SUBSCRIBER: ☐ SELF ☐ OTHER: _____

IF OTHER: RELATIONSHIP TO PATIENT: _____ DOB: _____

SECONDARY INSURANCE: _____

SUBSCRIBER: ☐ SELF ☐ OTHER: _____

IF OTHER: RELATIONSHIP TO PATIENT: _____ DOB: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL STATEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Hillcrest Internal Medicine, A Medical Corporation, or any other assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and any reasonable attorney's fees incurred. I hereby authorize this healthcare provider to release, to the insurance company, any information necessary to secure the payment of benefits.

MEDICAL POLICY

I understand that nurse practitioners may be involved in my healthcare at this office. I understand as a patient that if I decline or fail to do the diagnostic tests, the practitioner cannot be responsible for the consequences. I understand that if I do not hear about tests it is my responsibility to contact my practitioner for results.

SIGNATURE: _____ **DATE:** _____

HILLCREST INTERNAL MEDICINE

PRESCRIPTIONS & REFILLS:

Please contact your pharmacy to request additional refills. If you do not have any refills available the pharmacy will request them for you.

If your pharmacy says they will process the request, DO NOT call office, unless your refill has not been processed within a few days.

You can also request your refills through the patient portal, please make sure you let us know what pharmacy you wish to use.

Please plan ahead, refills usually require a minimum of 48 hours to process.

Most of your prescriptions are done electronically.

Controlled prescriptions -If your doctor is out of the office our Nurse Practitioner can only fill a 30-day prescription.

PATIENT RESPONSIBILITY:

It is the patient's responsibility to make sure we have the correct insurance information and that we accept your insurance. If you have an HMO, it must be through Mercy Physicians Medical Group with the name of the doctor in this practice, it is the patient's responsibility to confirm this information before your appointment. It is also the patient's responsibility to make sure we have all your updated information, current address, phone number, insurance information, etc.

To be on time for your scheduled appointment, you are required to sign in 15 minutes before your schedule appt. If you are late for your appt you may have to reschedule.

If you do not hear from us after two weeks of completing lab or diagnostic testing it is the patient's responsibility to contact your practitioner for results.

Co-pays are due the day of your appt., before you see the doctor.

It is your responsibility to pay for any charges that your insurance does not cover, some tests or services recommended by your doctor may not be covered by your insurance.

There is a $25.00 fee for missed or cancelled appointments without a 24-hour notice.

AFTER HOURS:

Controlled substances will not be refilled after office hours.

Please do not call the doctor on call to request routine refills either after hours or on weekends. They can be requested over the patient portal, but will most likely not be refilled until normal business hours.

PATIENT PORTAL:

The patient portal is NOT to be used for emergencies, there is a doctor on call for emergencies after hours and weekends. The patient portal is normally not accessed after hours, weekends or holidays. If you have not heard from the office within 48 business hours, please call the office.

PHONE CALLS:

All urgent phone calls will be returned as promptly as possible. Most calls will be returned by end of day or possibly the next day. Any non-urgent calls after 4:00 will be handled the next business day. A medical assistant will only call you for urgent prescription request, such as antibiotics- **Please check with your pharmacy for all your refill request.**

TREATMENT:

If you need an appointment, you may have to be seen by one of our Nurse Practitioners or accept the 1st available appointment with your doctor. For all medical issues that require a doctor's advice you may be asked to come in.

I understand as a patient that if I decline or fail to do diagnostic test the practitioner cannot be responsible for the consequences. I understand that if I do not hear about test results after two weeks, it is my responsibility to contact my practitioner for results. I understand that I am responsible for all charges that my insurance does not cover.

HILLCREST INTERNAL MEDICINE COMPANY POLICY

I have read and understand the policies of Hillcrest Internal Medicine

Print name_____ **Date of Birth**_____

Signature_____Date: _____

HIPAA RELEASE AUTHORITY: A SPOUSE, CHILD, RELATIVE, FRIEND, ETC.

I intend for the person named below to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by (HIPAA), 42 USC 132od and 45 CFR 160-164. I authorize:

a. Any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or other health care clearing house that has provided me treatment or services, or that has paid for or is seeking payment from me of such services.
b. To give, disclose and release to the person named below, without restriction: All of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

I HEREBY AUTHORIZE: name of authorized person i.e.: (spouse, child, relative, friend, etc.):

_____

Address: _____

Telephone: _____

Relationship: _____

TO HAVE ACCESS TO MY MEDICAL RECORDS AS INDICATED ABOVE.

The authority given shall supersede any prior agreement that I may have made with my health care providers to restrict access or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority, in writing, and deliver it to my health care provider.

Patient signature: _____ Date: _____

Patient (Print Name) _____

Patients Date of Birth: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

Name (print)	Date
Signature	Telephone

If not signed by the patient, please indicate relationship:

- ☐ Parent or Guardian of minor patient
- ☐ Guardian or Conservator of incompetent patient

Name of Patient

ADVANCE DIRECTIVES AND DO NOT RESUSCITATE ORDERS

What is an advance directive?

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example.) If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.

A good advance directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are.

Advance directives can take many forms. Laws about advance directives are different in each state. You should be aware of the laws in your state.

What is a living will?

A living will is one type of advance directive. It only comes into effect when you are terminally ill. Being terminally ill generally means that you have less than six months to live. In a living will, you can describe the kind of treatment you want in certain situations. A living will doesn't let you select someone to make decisions for you.

What is a durable power of attorney for health care?

A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

Living wills and DPAs are legal in most states. Even if they aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer or state representative about the law in your state.

What is a do not resuscitate order:

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

Most patients who die in a hospital have a DNR order written for them. Patients who are not likely to benefit from CPR include people who have cancer that has spread, people whose kidneys don't work well, people who need a lot of help with daily activities, or people who have severe infections such as pneumonia that require hospitalization.

If you already have one or more of these conditions, you should go to the hospital. It's best to do this early, before you are very sick and considered unable to make your own decisions.

Should I have an advance directive?

Most advance directives are written by older or seriously ill people. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

How can I write an advance directive?

You can write an advance directive in several ways:

- Use a form provided by your doctor.
- Write your wishes down by yourself.
- Call your state senator or state representative to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

Can I change my advance directive?

You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.

If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

COMPLETE THIS PORTION OF ADVANCE DIRECTIVE FORM

I, _____ write this document as a directive regarding my medical care.

In the following sections, put the initials of your name in the blank spaces by the choices you want.

PART 1. My Durable Power of Attorney for Health Care

_____ I appoint this person to discuss my medical care with my doctor and make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctors, my family and others to be guided by the decisions I have made in the parts of the form that follow:

Name: _____

Home Telephone: _____

Work Telephone: _____

Address: _____

If the person above cannot or will not make decisions for me, I appoint this person:

Name: _____

Home Telephone: _____

Work Telephone: _____

Address: _____

_____ I have not appointed anyone to make health care decisions for me in this or any other document.

PART 2. My Living Will

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. These are my wishes if I have a terminal condition.

Life-sustaining treatments

_____ I do not want life-sustaining treatment (including CPR) started. If life-sustaining treatments are started, I want them stopped.

_____ I want the life-sustaining treatments that my doctors think are best for me.

_____ Other wishes

Artificial nutrition and hydration

_____ I do not want artificial nutricial and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.

_____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.

_____ Other wishes

Comfort care

_____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.

_____ Other wishes

B. These are my wishes if I am ever in a persistent vegetative state.

_____

_____

_____

PART 3. Other Wishes

A. Organ donation

_____ I do not wish to donate any of my organs or tissues.

_____ I want to donate all of my organs and tissues.

_____ I only want to donate these organs and tissues:

_____

_____ Other wishes

_____

B. Autopsy

_____ I do not want an autopsy.

_____ I agree to an autopsy if my doctors wish it.

_____ Other wishes.

_____

C. Other statements about your medical care

If you wish to say more about any of the choices you have made or if you have any other statements to make about your medical care, you may do so on a separate piece of paper. If you do so, put here the number of pages you are adding: _____

PART 4. Signatures

You and two witnesses must sign this document before it will be legal.

A. Your signature

By my signature below, I show that I understand the purpose and the effect of this document.

Signature: _____ Date: _____

Address: _____

B. Your witnesses' signatures

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence and that he/she appears not to be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive.

Witness #1

Signature: _____ Date: _____

Address: _____

Witness #2

Signature: _____ Date: _____

Address: _____