VISALIA MEDICAL CLINIC, INC.



MEDICAL QUESTIONNAIRE

#OTHRVIST - 002

Due to government requirements that physicians document complete medical information on each patient, we ask you to complete the following detailed form in its entirety. Should you have trouble with any of the questions, please feel free to ask our staff for assistance. Some of the information may be sensitive; rest assured that the staff will keep this information confidential. Thank you for your cooperation.

1. PATIENT IDENTIFICATION		
Name:		
Age: Date of Birth: Who is	s your primary / family doctor?:	
How were you referred to our office: ☐ Self	☐ ER (which one?):	
☐ Referred By (name):	Other (list name):	
2. PRESENTING COMPLAINT / PROBLEM		
Reason for visit:	Date of onset:	
Cause of injury:		
Work-related?: ☐ Yes ☐ No	Previous injury?:	
Previous studies? Where performed & Date?		
X-Rays	MRI	
CT Scan	CT ScanBone Scan	
Other	Nerve Conduction Studies	
☐ Right Handed ☐ Left Handed		
PAIN D	RAWING	
Be sure to fill this out extremely accurately. Mark to sensation. Use the appropriate symbol. Mark area	he area on your body where you feel the s of radiation. Include all affected areas.	described
Numbness = = = = Pins & Needles o o o o Burnir	ng Pain x x x x Stabbing Pain / / / Achir	ng Pain ((((
No Pain	Severe Pain	
0 1 2 3 4	5 6 7 8 9 10	
PAIN	SCALE	
		and the second

3. I	TEDICAL HISTORY					
200	CHECK YES or NO to indicate	if you have EVER had any of the	e following disorders, and ci	rcle the approp	oriate con	dition.
	General: Rheumatoid Arthr	itis, Cancer (where)			☐ Yes	
	Eyes / Ears: Glaucoma, Hearing Loss			☐ Yes	☐ No	
	Neuro: Migraine headaches, Seizures, Epilepsy, Stroke, Polio, Nerve Injury, Meningitis			☐ Yes	☐ No	
	Endocrine: Diabetes, Thyroid Disorder, Adrenal Insufficiency			Yes	☐ No	
	Cardiac: Coronary Artery Disease, Angina, Heart Attack, Arrhythmia, Valve Disease, Rheumatic Fever, Stents			Yes	☐ No	
	Respiratory: Asthma, Emphysema, Tuberculosis, Blood clot to lungs, Bronchitis, Pneumonia			Yes	☐ No	
	GI: Reflux / Ulcer Disease, Liver Disease / Hepatitis, Bowel Disease			☐ Yes	☐ No	
	GU: Kidney Disease, Renal Failure, Urinary Problems, Prostate Problems, Infections			☐ Yes	☐ No	
	Vascular: High blood pressure, Phlebitis, DVT / Clot, Anemia, Bleeding Disorder			☐ Yes	☐ No	
	Psych: Mental illness, Depr	ression, Bipolar Disorder, Anx	iety		☐ Yes	☐ No
		thritis, Osteoporosis, AIDS, S			☐ Yes	☐ No
					☐ Yes	
4.		HOSPITALIZATIONS - lis				
	Any complications with su	urgery or anestnesia?: E HERBAL SUPPLEMENT	IS AND OVER THE COL	INTER MED	CATION	vs.
5.		DOSE # TIMES PER DAY	The state of the s	DOSE # TIM		
	MEDICATION	DOSE # TIMES I EN DAT	WEDIOATION	BOOL II THE		1 5/11
6.	ALLERGIES (DRUG REA	cugs or have you had any r	reactions to medications	?	☐ Yes	D No.
	If YES, LIST the drugs ar	nd the type of reaction:			u ies	- NO
				10.00		
7.	FAMILY HISTORY (biolog	ical grandparents, parent	s, siblings) – is there a n, heart disease, cancer	family histor ?	y of an	y serious
Ш	7. FAMILY HISTORY (biological grandparents, parents, siblings) – is there a family history of any serious medical conditions – such as diabetes, hypertension, heart disease, cancer? Yes No if YES, please explain:					
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8.	SOCIAL HISTORY			
	☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children living			
	Presently living alone? Yes No			
	Stairs at home? Yes No Number of steps			
	Occupation:Still at work? Yes No if no, last date worked:			
	How long at present job?			
	Physical demands of work: Heavy Moderate Light Lifting Pushing			
	☐ Squatting ☐ Prolonged standing ☐ Sitting			
	Alcohol use: Never Rare Coccasional Moderate Heavy Quit how many years ago?			
	Tobacco use: Nonsmoker Smoker #packs per dayYears			
	☐ Previous Smoker How many years ago?			
	Drug use: Yes No Past What type?			
	Sports / Exercise prior to injury? Yes No What type?			
	Number of times/week: Recreational School / College level Semi / Professional			
0	How has injury affected these activities? REVIEW OF SYSTEMS General Health: Good Average Fair Poor			
9.				
	Circle to indicate if you have had any of the following symptoms pertaining to today's visit only.			
	Unexplained weight loss, Fatigue, Fever, Chills. Blurred vision			
	Hearing loss, Ringing in ears, Hoarseness, Sore throat			
	Chest pain, Palpitations, Irregular heart beat, Murmur, Racing heart, Lower ext. edema			
	Shortness of breath, Cough, Blood in sputum, Wheezing, Sleep apnea			
	Abdominal pain, Constipation, Diarrhea, Vomiting blood, Black stool, Nausea, Jaundice			
	Burning with urination, Urinary frequency, Blood in urine			
	Bone or joint infections, Swollen joint, Gout, metal implant, fractures or dislocations			
	Skin color changes, Rashes, Lesions, Nodule, Skin ulcers			
	Headache, Dizziness, Seizures, Difficulty walking, Tingling			
	Anxiety, Depression, Nervousness, Insomnia			
	Bruise easily, Swollen glands, Nosebleeds, Gum bleeding, Blood disorders			
	Prior blood transfusions? If yes, when			
	Are you claustrophobic? YES or NO Are you pregnant? YES or NO			
	Other symptoms? Please specify			
	Patient Signature Date			
	I have reviewed this form and used the data in forming my opinion and making recommendations			
	Physician's SignatureDate			
	Physician's SignatureDate			

Orthopedic Department VISALIA MEDICAL CLINIC, INC.

5400 W. Hillsdale + Visalia, CA 93291 Phone: 559/738-7550-559/738-7541 ~ Fax: 559/738-7586

PATIENT CONSULTATION REQUEST FORM

Patient Information	
Name:	
DOB:	Telephone:
Insurance:	
Authorization# (if needed):	
Date of Request:	
Requested by: Dr.	Address:
Phone Number:	Fax:
☐ Consultation & treatment if needed we ☐ James Guadagni, M.D. ☐ Jason Mihalcin, D.O. ☐ Jeff Rubio, P.A. ☐ Or next available appointment	
☐ Transfer of care	
Reason for consultation (please be specif	îc):
Signature of Requesting Physician:	

Note: Please fax this <u>completed form, pertinent progress notes, labs, x-rays and a copy of the patient's insurance card</u> to our office as quickly as possible. Failure to return the completed form and records may result in a delay in scheduling the patient's appointment.

Please file completed form in patient's chart \$50.00 FEE FOR FAILED APPOINTMENTS