PATIENT HEALTH QUESTIONNAIRE: FULLERTON UROLOGY

PATIENT'S NAME: _____ SEX ____ M ____ F
FIRST MIDDLE LAST

HOME ADDRESS: _____
STREET APT # CITY STATE ZIP CODE

PHONE #: ( )_____ EMAIL: _____

DATE OF BIRTH: _____/_____/_____ AGE:_____ SSN:_____-_____-_____ DRIVER'S LICENSE #:_____

TYPE OF VISIT: ___Consultation requested by another Physician ___Self-referred ___Second Opinion

A. PHYSICIAN INFORMATION

PRIMARY CARE MD: _____
ADDRESS: _____
PHONE #: ( ) _____ FAX #: ( )_____

REFERRING PHYSICIAN: _____ SPECIALTY: _____
ADDRESS: _____
PHONE #: ( ) _____ FAX #: ( )_____

B. INSURANCE: **PLEASE SHOW ALL INSURANCE CARDS TO RECEPTIONIST**

_____
PRIMARY INSURANCE COMPANY INSURED POLICY NUMBER GROUP NUMBER

ADDRESS:_____PHONE # ( )_____

_____
SECONDARY INSURANCE COMPANY INSURED POLICY NUMBER GROUP NUMBER

ADDRESS:_____PHONE #: ( )_____

C. IN CASE OF EMERGENCY:

NAME:_____RELATIONSHIP TO PATIENT:_____

ADDRESS:_____PHONE # ( )_____

I hereby authorize above named physician(s) to furnish to the above insurance company(s) or to designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign to above physician(s) all money to which I am entitled for medical and/or surgical expense relative to the service rendered by them, but not to exceed my indebtedness to said medical group. It is understood that any money received from the above named insurance company(s) over and above my indebtedness group for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection and/or court fees.

_____ _____
INSURED/GUARDIAN SIGNATURE PATIENT SIGNATURE

PATIENTS NAME:_____ D.O.B._____

D. CHIEF COMPLAINT (the main reason for seeking medical attention):

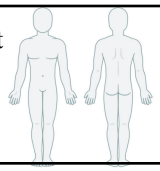
_____

_____

E. HISTORY OF PRESENT ILLNESS Briefly describe your symptoms, when they started and treatment you have received.

_____

_____

Location of the problem Front  Back Abdomen Back Leg Other _____	**How long does the problem last?** 30 minutes 1 hour It is always there Other _____
On a scale of 1-10, with 10 being the most severe, circle the number that BEST describes the problem: 1 2 3 4 5 6 7 8 9 10	**Is the problem constant or variable?** Dull then sharp Very sharp then leaves Always there Other _____
When did you first notice the problem? 2 days ago 2 weeks ago 1 month ago Other _____	**Does the problem interfere with your normal functions?** Yes No If yes, please explain:
Does anything help or make the problem worse? Moving around Standing up Lying on my side Other _____	**Is anything else occurring at the same time?** Yes No If yes, please explain: Nausea Rash Headaches Other _____

F. SOCIAL HISTORY

Check the one that applies:

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Legally Separated
- ☐ Annulled

Ethnicity
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Decline

Race
- ☐ White
- ☐ Black/African American
- ☐ American Indian
- ☐ Alaskan Native/Eskimo
- ☐ Hispanic/Latino
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander

Language
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ German
- ☐ Portuguese
- ☐ Russian
- ☐ Chinese
- ☐ Japanese
- ☐ Italian
- ☐ Vietnamese
- ☐ Arabic

☐ Other

Smoking:

Do you smoke? ___Yes ___No If yes, # packs per day: _____
___Cigarettes ___Cigars ___Pipe How many years? _____
___Everyday ___Somedays
Smokeless Tobacco? ___Yes ___No ___Snuff ___Chew
Are you an ex-tobacco user? ___Yes ___No If yes, when did you quit? _____
Are you ready to quit? ___Yes ___No
Are you interested in smoking cessation counseling? ___Yes ___No

Alcohol Use: ___Yes ___No
Use/Week _____ Amount of alcohol/Week _____ (oz.)

Caffeine Intake: ___Yes ___No If yes, # of drinks per day: ___1 ___2 ___3 ___4+
Do you use recreational drugs: ___Yes ___No
Have you had a blood transfusion? ___Yes ___No

G. PREFERRED LABORATORY ___Quest ___Labcorp

(Location: Street and City): _____

H. PREFERRED PHARMACY

Name of Local Pharmacy: _____
Address/Location of Pharmacy: _____
Phone number: _____
Mail Order Pharmacy Name: _____
Mail Order Pharmacy Phone Number: _____
Mail Order Pharmacy Fax Phone Number: _____
Mail Order Pharmacy ID #: _____

I. PAST MEDICAL HISTORY

Adult Illnesses: Have you ever had any of the following? (Please check)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Clotting Disorder
- ☐ Colon Polyps
- ☐ COPD
- ☐ CAD
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated PSA
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Infertility
- ☐ Inflammatory Bowel Disease
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ PVD
- ☐ Seizures
- ☐ Spina Bifida
- ☐ Sexually Transmitted Infection (STI)
- ☐ Ulcers
- ☐ UTI

Other: _____

_____

J. PAST SURGICAL HISTORY

- ☐ Aneurysm Repair
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ C-Section
- ☐ CABG
- ☐ Carotid Artery Angioplasty/Stent
- ☐ Cholecystectomy
- ☐ Colon Surgery
- ☐ Cystoscopy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Kidney Removal
- ☐ Kidney Transplant
- ☐ Lithotripsy (ESWL)
- ☐ Oophorectomy
- ☐ Penile Surgery
- ☐ Prostate Surgery
- ☐ Small Intestine Surgery
- ☐ Stone Surgery
- ☐ Testical Removal
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Urinary Diversion
- ☐ Valve Replacement
- ☐ Vasectomy

Other: _____

_____

K. FAMILY HISTORY

☐ Anesthesia Problems	☐ Mom	☐ Dad	☐ Other: _____
☐ Clotting Disorder	☐ Mom	☐ Dad	☐ Other: _____
☐ Heart Disease	☐ Mom	☐ Dad	☐ Other: _____
☐ Hypertension	☐ Mom	☐ Dad	☐ Other: _____
☐ Kidney Cancer	☐ Mom	☐ Dad	☐ Other: _____
☐ Prostate Cancer	☐ Mom	☐ Dad	☐ Other: _____
☐ Kidney Disease	☐ Mom	☐ Dad	☐ Other: _____
☐ Diabetes	☐ Mom	☐ Dad	☐ Other: _____
☐ Urolithiasis (Urinary Stones)	☐ Mom	☐ Dad	☐ Other: _____
☐ Stroke	☐ Mom	☐ Dad	☐ Other: _____
☐ Depression	☐ Mom	☐ Dad	☐ Other: _____
☐ Alcohol Abuse	☐ Mom	☐ Dad	☐ Other: _____

Other Family History: _____

L. REVIEW OF SYSTEMS In the last three (3) months, have you experienced any of the following:

Yes	If "Yes" Please Explain	Yes	If "Yes" Please Explain
Constitutional		**Eyes**	
☐ Chills	_____	☐ Eye Itching	_____
☐ Diaphoresis	_____	☐ Eye Pain	_____
☐ Fever	_____	☐ Eye Redness	_____
☐ Headache	_____	☐ Visual Disturbance	_____
		☐ Double Vision	_____
Respiratory			
☐ Chest Tightness	_____	**Cardiovascular**	
☐ Cough	_____	☐ Chest Pain	_____
☐ Short of Breath	_____	☐ Leg Swelling	_____
☐ Wheezing	_____	☐ Palpitation	_____

GI/Abdomen

- ☐ Abdominal Pain _____
- ☐ Nausea _____
- ☐ Vomiting _____
- ☐ Indigestion _____
- ☐ Heartburn _____

Female GU

- ☐ Difficult Urination _____
- ☐ Dyspareunia _____
- ☐ Dysuria _____
- ☐ Enuresis _____
- ☐ Flank Pain _____
- ☐ Frequency _____
- ☐ Genital Sore _____
- ☐ Hematuria _____
- ☐ Menstrual Problem _____
- ☐ Pelvic Pain _____
- ☐ Urgency _____
- ☐ Vaginal Bleeding _____
- ☐ Vaginal Discharge _____
- ☐ Vaginal Pain _____

Male GU

- ☐ Difficult Urination _____
- ☐ Dysuria _____
- ☐ Enuresis _____
- ☐ Flank Pain _____
- ☐ Frequency _____
- ☐ Genital Sore _____
- ☐ Hematuria _____
- ☐ Penile Discharge _____
- ☐ Penile Pain _____
- ☐ Penile Swelling _____
- ☐ Scrotal Swelling _____
- ☐ Testicular Pain _____
- ☐ Urgency _____
- ☐ Urine Decrease _____

Miscellaneous

- ☐ Arthralgia _____
- ☐ Back Pain _____
- ☐ Gate Problem _____
- ☐ Joint Pain/Swelling _____
- ☐ Neck Pain _____
- ☐ Back Pain _____
- ☐ Stiff Neck _____

Allergy/Immunology

- ☐ Environmental _____
- ☐ Food _____
- ☐ Immunocompromised _____

Neurological

- ☐ Dizziness/Dizzy Spells _____
- ☐ Facial Asymmetry _____
- ☐ Headaches _____
- ☐ Lightheadedness _____
- ☐ Numbness/Tingling _____
- ☐ Seizures _____
- ☐ Speech Difficulty _____
- ☐ Syncope _____
- ☐ Tremors _____
- ☐ Weakness _____

Hematologic

- ☐ Adenopathy _____
- ☐ Bruise/Bleed Easy _____
- ☐ Blood Clotting Issues _____

Psychiatric

- ☐ Agitation _____
- ☐ Behavior Problem _____
- ☐ Confusion _____
- ☐ Low Concentration _____
- ☐ Dysphoric Mood _____
- ☐ Hallucinations _____
- ☐ Hyperactive _____
- ☐ Nervous/Anxious _____
- ☐ Self Injury _____
- ☐ Sleep Disturbance _____
- ☐ Suicidal Ideations _____

Endocrine

- ☐ Excessive Thirst _____
- ☐ Too Hot/Cold _____
- ☐ Tired/Sluggish _____

Integumentary/Skin

- ☐ Color Change _____
- ☐ Pallor _____
- ☐ Rash _____
- ☐ Wound _____
- ☐ Boils _____
- ☐ Persistent Itching _____

SEXUAL ORIENTATION AND GENDER IDENTITY QUESTIONS

Sexual Orientation

Do you think of yourself as:

- ☐ Straight or Heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

Gender Identity

What is your current gender identity? (Check one):

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/Female-to-Male (FTM)
- ☐ Transgender Female/Trans Woman/Male-to-Female (MTF)
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional Gender Category/(or Other), please specify: _____
- ☐ Choose not to disclose

What sex were you assigned at birth on your original birth certificate? (Check one):

- ☐ Male
- ☐ Female
- ☐ Choose not to disclose

NAME AND PRONOUNS QUESTIONS

Name(s) Used:

_____

Pronouns:

- ☐ He/Him
- ☐ She/Her
- ☐ They/Them
- ☐ Other _____

M. <u>ALLERGIES</u> Please list all medications to which you are allergic. Include any reactions you have had to x-ray dyes (iodine)

MEDICATION	TYPE OF REACTION

N. <u>MEDICATIONS</u> List any medications you are now taking (including vitamins and all non-prescription drugs). Copy names and dosages of medication from the prescription label. Please bring all medications with you to your first visit.

NAME OF MEDICATION	DOSE (MGS, Tablets)	FREQUENCY

AUTHORIZATION TO CONTEST TO TREATMENT OF A MINOR

(I) (We), the undersigned parent(s) of _____, a minor, do hereby authorize **Marinelli & Feldman M.D.s** as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain until _____ unless sooner revoked in writing and delivered to the said agent(s).

Dated _____

_____
Father

_____
Witness

_____
Mother

_____
Witness

_____
Legal Guardian

MARINELLI & FELDMAN, M.D.'s
UROLOGY
Ali Alavi, M.D. Alexa Chai, M.D. Derrick Marinelli, M.D.
1915 Sunny Crest Dr. Fullerton, CA 92835
Office (714) 879-2410
Fax (714) 879-5340

CREDIT POLICY

Medical insurance plans vary in their requirements necessary for benefits to be allowed. It is your responsibility to know the requirements that pertain to your specific plan. To ensure insurance coverage for medical services, we encourage you to know your yearly deductible and copay, when precertification is required, and what facilities (hospital, lab, x-ray) you may use, etc. This information is available to you either in your handbook, from your employer, or directly from your insurance company.

BILLING PERIOD: All copayments and deductibles are payable at the time that your medical services are rendered. Your primary insurance company will be billed. Upon payment from them, your secondary insurance company will be billed. Any unpaid balance is due upon receipt of your statement. Under California State Law (Know-Knee-Act) all medical insurance companies are required to process and pay claims within 30 days. We allow 60 days for your claim to be paid by your primary insurance company and 30 days for your secondary insurance company. If your claim remains unpaid after these billing periods, you will be responsible for the payment of your total charges.

NON-COVERED SERVICES: Insurance companies pay only for medical services that they determine to be medically necessary. If your insurance company determines that a service is not medically necessary or is non-covered, you will be responsible for payment.

PPO/POS/EPO/MEDICARE: These plans have a network of participating physicians who are contracted to accept discounted fees. If we are participating in your plan's network, your account will be discounted according to our contract with your insurance company.

HMO: These plans have a network of participating physicians who are contracted with an IPA group (i.e. Caremore, Prospect, St. Jude's, Alignment). Services must always be authorized by your IPA prior to being rendered. It is your responsibility to inform our office of any changes such as primary care doctor or IPA group.

RETURNED CHECKS: You will be charged a **$25.00** processing fee for all returned checks.

AUTHORIZATION: I authorize the release of my medical records or other information deemed necessary to my insurance company in order to process my insurance claims. I authorize payment of medical benefits to Marinelli & Feldman, M.D.'s for services rendered.

I acknowledge and agree to the above terms.

Dated _____ _____
Print Name

_____
Signature

MARINELLI AND FELDMAN, M.D.'S

DERRICK V. MARINELLI, M.D. ALI S. ALAVI, M.D. ALEXA CHAI, M.D.

1915 SUNNYCREST DR FULLERTON, CA 92835

(714)879-2410

HIPAA-PRIVACY AUTHORIZATION FORM

*Authorization for Use or Disclosure Of Protected Health Information. (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization:

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____

(individual seeking the information).
2. Effective Period:

This authorization for release of information covers the period of healthcare from:

a. _____ to _____

b.___ all past, present, and future periods.
3. Extent of Authorization:

a.___ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol, and or drug abuse).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claim payments, or any other purpose as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization, or if any authorization was obtained as a condition to access insurance coverage, and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, and or eligibility for benefits will not be conditioned on whether I sign this authorization or not.

8. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient, and may no longer be protected by Federal or State law.

_____

PATIENT SIGNATURE/PERSONAL REPRESENTATIVE **DATE**