LANCASTER CARDIOLOGY MEDICAL GROUP / FIRST VALLEY MEDICAL GROUP HEALTH QUESTIONNAIRE

PRIMARY LANGUAGE: _____ **DATE:** _____

NAME: _____ **SSN :** _____

ADDRESS _____ PHONE: _____
STREET CITY STATE ZIP

AGE: _____ **DATE OF BIRTH:** _____ **HEIGHT:** _____ **WEIGHT:** _____

FAMILY PHYSICIAN _____
NAME ADDRESS

OCCUPATION _____ **EMPLOYER** _____

CHIEF COMPLAINT: _____

DURATION: _____ **DATE OF ONSET** _____

ANY OTHER COMPLAINT _____

DURATION _____

PAST MEDICAL HISTORY (LIST ILLNESS)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

HOSPITALIZATIONS (HOW MANY AND WHERE) _____

_____

_____

OPERATIONS (LIST THE TYPE) _____

_____

ALLERGIES (MEDICATIONS AND/OR FOOD)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

LIST MEDICATIONS YOU ARE TAKING

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

HAS ANY BLOOD RELATIVE EVER HAD THE FOLLOWING: (CIRCLE ONE)

CANCER	YES	NO
T.B.	YES	NO
DIABETES	YES	NO
HEART TROUBLE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
STROKE	YES	NO
CONVULSIONS	YES	NO

BLEEDING TENDENCY	YES	NO
ARTHRITIS	YES	NO
ANEMIA	YES	NO
PSYCHIATRIC PROBLEM	YES	NO

ANY DECEASED IN FAMILY (LIST CAUSE OF DEATH)

1._____ _____
2._____ _____
3._____ _____

ARE YOU: **MARRIED** **SINGLE** **SEPARATED** **DIVORCED** **WIDOWED**

HABITS

DO YOU SMOKE? YES NO HOW MANY? _____

DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____

SYSTEM REVIEW: DO YOU HAVE ANY OF THE FOLLOWING?

GENERAL:

RECENT WEIGHT CHANGE	YES	NO
HAVE YOU BEEN IN GOOD GENERAL HEALTH MOST OF YOUR LIFE	YES	NO
DO YOU HAVE A FEVER/CHILLS	YES	NO

SKIN:

SKIN DISEASE	YES	NO
JAUNDICE	YES	NO
HIVES, ECZEMA, OR RASH	YES	NO
FREQUENT INFECTION OR BOILS	YES	NO
ABNORMAL PIGMENTATION	YES	NO

HEAD-EYES-EARS-NOSE-THROAT:

EYE DISEASE OR INJURY	YES	NO
DO YOU WEAR GLASSES	YES	NO
DOUBLE VISION	YES	NO
HEADACHES	YES	NO
GLAUCOMA	YES	NO
ITCHING EYES OR NOSE	YES	NO
SNEEZING OR RUNNY NOSE	YES	NO
NOSEBLEEDS	YES	NO
CHRONIC SINUS TROUBLE	YES	NO
EAR DISEASE	YES	NO
IMPAIRED HEARING	YES	NO
DIZZINESS OR TRANSIENT EPISODES OR UNCONSCIOUSNESS	YES	NO

NECK:

STIFFNESS	YES	NO
THYROID TROUBLE	YES	NO
ENLARGED GLANDS	YES	NO

RESPIRATORY:

COLD (NOW)	YES	NO
SPITTING UP BLOOD	YES	NO
CHRONIC OR FREQUENT COUGH	YES	NO
ASTHMA OR WHEEZING	YES	NO
DIFFICULTY BREATHING	YES	NO
ANY TROUBLE WITH LUNGS	YES	NO
PLEURISY OR PNEUMONIA	YES	NO

CARDIOVASCULAR:

DIZZY SPELLS	YES	NO
CHEST PAIN OR ANGINA PECTORIS	YES	NO
SHORTNESS OF BREATH WITH WALKING OR LYING DOWN	YES	NO
DIFFICULTY WALKING TWO BLOCKS	YES	NO
HEART TROUBLE OR HEART ATTACKS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
SWELLING OF HANDS, FEET, ANKLES	YES	NO
HEART MURMUR	YES	NO
PALPITATIONS	YES	NO

GASTROINTESTINAL:

PEPTIC ULCER (STOMACH OR DUODENAL)	YES	NO
VOMITING BLOOD OR FOOD	YES	NO
GALLBLADDER DISEASE	YES	NO
LIVER TROUBLE	YES	NO
HEPATITIS	YES	NO
PAINFUL BOWEL MOVEMENTS	YES	NO
BLEEDING WITH BOWEL MOVEMENTS	YES	NO
BLACK STOOLS	YES	NO
HEMORRHOIDS OR PILES	YES	NO
RECENT CHANGE IN BOWEL HABITS	YES	NO
FREQUENT DIARRHEA	YES	NO
HEARTBURN OR INDIGESTION	YES	NO

CRAMPING OR PAIN IN THE ABDOMEN YES NO

DOES FOOD STICK IN THROAT YES NO

CONSTIPATION YES NO

GENITOURINARY:

LOSS OF URINE YES NO

FREQUENT URINATION YES NO

NIGHT TIME URINATING YES NO

BURNING OR PAINFUL URINATION YES NO

BLOOD IN URINE YES NO

KIDNEY TROUBLE YES NO

KIDNEY STONES YES NO

BRIGHT'S DISEASE YES NO

GYNECOLOGICAL:

AGE PERIODS STARTED_____HOW MANY DAYS DO PERIODS LAST_____

ANY PAIN WITH YOUR PERIODS YES NO

DATE OF FIRST DAY OF LAST PERIOD: _____

NUMBER OF PREGNANCIES: _____

NUMBER OF MISCARRIAGES: _____

NUMBER OF CHILDREN: _____AGES:_____

LOCOMOTOR-MUSCULOSKELETAL:

VARICOSE VEINS YES NO

WEAKNESS OF MUSCLES OR JOINTS YES NO

ANY DIFFICULTY IN WALKING YES NO

ANY PAIN IN CALVES OR BUTTOCKS WHILE WALKING, YES NO

RELIEVED BY REST

NEURO-PSYCHIATRIC:

BLURRING OF VISION YES NO

HEADACHE YES NO

HEAD INJURY YES NO

CONVULSIONS YES NO

PARALYSIS YES NO

NUMBNESS YES NO

TINGLING YES NO

DIFFICULTY WITH URINE CONTROL YES NO

SPEECH TROUBLE YES NO

MEMORY LOSS YES NO

LOSS OF CONSCIOUSNESS YES NO

HEMATOLOGIC:

ARE YOU SLOW TO HEAL AFTER CUTS YES NO

BLOOD DISEASE YES NO

ANEMIA YES NO

PHLEBITIS YES NO

HAVE YOU HAD DIFFICULTY WITH BLEEDING EXCESSIVELY AFTER TOOTH EXTRACTION SURGERY YES NO

HAVE YOU HAD ABNORMAL BRUISING OR BLEEDING YES NO

ENDOCRINE:

THYROID DISEASE YES NO

HORMONE THERAPY YES NO

ANY CHANGE IN HAT OR GLOVE SIZE YES NO

HAVE YOU BECOME COLDER THAN BEFORE OR SKIN BECOME DRYER YES NO

SOURCE OF INFORMATION, IF OTHER THAN PATIENT: _____

SIGNATURE OF PERSON ACQUIRING THIS INFORMATION: _____

_____ _____ _____

DOCTOR DATE SIGNATURE OF PATIENT

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF PRIVACY POLICIES

FOR

LANCASTER CARDIOLOGY MEDICAL GROUP/FIRST VALLEY MEDICAL GROUP

Revision Number ____0____.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Lancaster Cardiology Medical Group/First Valley Medical Group, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Lancaster Cardiology Medical Group/First Valley Medical Group, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Lancaster Cardiology Medical Group/First Valley Medical Group, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Lancaster Cardiology Medical Group/First Valley Medical Group is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, at 661-948-7608.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

TEST, PATIENT

Lancaster Cardiology Medical Group/First Valley Medical Group

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:_____ Date:_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnesses by:_____

Internal-Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):_____

By: (name and title): _____

TEST, PATIENT DOB:

Do I have to fill out one of these forms?

No, you do not have to fill out any of these forms if you don't want to. You can just talk with your doctors and ask them to write down what you've said in your medical chart. And you can talk with your family. But people will be more clear about your treatment wishes if you write them down. And your wishes are more likely to be followed if you write them down.

Will I still be treated if I don't fill out these forms?

Absolutely. You will still get medical treatment. We just want you to know that, if you become too sick to make decisions, someone else will have to make them for you. Remember that:

√ A DURABLE POWER OF ATTORNEY FOR HEALTH CARE lets you name someone to make treatment decisions for you. That person can make most medical decisions - not just those about life-sustaining treatment – when you can't speak for yourself. Besides naming an agent, you can also use the form to say when you would and wouldn't want particular kinds of treatment.

√ If you don't have someone you want to name to make decisions when you can't, you can sign a NATURAL DEATH ACT DECLARATION. This DECLARATION says that you do not want life prolonging treatment if you are terminally ill or permanently unconscious.

How can I get more information about advance directives?

Ask your doctor, nurse, or social worker to get more information for you.

☐ No, I decline further information at this time.

☐ Yes, I would like to receive further information.

Patient's Signature Date

☐ Patient provided written information on advance directives.

Staff's Signature Title

Your Right To Make Decisions About Medical Treatment

This brochure explains your rights to make health care decisions and how you can plan what should be done when you can't speak for yourself.

A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

First Valley Medical Group / Lancaster Cardiology Medical Group, Inc.

43847 N Heaton Avenue
Lancaster, CA 93534
(661) 726-3

43860 N 10th Street West
Lancaster, CA 93534
(661) 726-3

1535 N China Lake Blvd., Suite A
Lancaster, CA 93534
(760) 446-1690

PATIENT REGISTRATION (PLEASE PRINT) REFERRED BY:_____
PLEASE COMPLETE BOTH SIDES OF THIS FORM

Primary Language : _____

Cell Phone # (___)_____

PATIENT INFORMATION

Patient's Name:_____ _____
Last First Middle Phone

Address:_____ _____
Street City State Zip Date of Birth

#_____ M _____ _____
Social Security Sex Marital Status Driver's License Number

Occupation:_____ (___)_____
Work Phone

Employer:_____

Work Address:_____
Street City State Zip

_____ _____ (___)_____
In Case Of Emergency Contact Relation Phone

SPOUSE/RESPONSIBLE PARTY INFORMATION

Responsible Party:_____ (___)_____
Last First Middle Phone

Address:_____ #_____
Street City State Zip Social Security

_____ _____ _____
Date of Birth Driver's License Number Relationship

Occupation:_____ (___)_____
Work Phone

Employer:_____

Work Address:_____
Street City State Zip

Spouse's Name:_____ (___)_____
Phone Number

Address:_____ #_____
Street City State Zip Social Security

Employer_____ _____
Work Phone

Work Address:_____
Street City State Zip

TEST, PATIENT

INSURANCE INFORMATION:

MediCare No._____ Medi-cal No._____

Private Insurance

(1) Company_____ Group No._____

Address:_____ Certificate No._____

_____ Subscriber No._____

City State Zip

(____)_____

Phone

(2) Company_____ Group No._____

Address:_____ Certificate No._____

_____ Subscriber No._____

City State Zip

(____)_____

Phone

(3) Company_____ Group No._____

Address:_____ Certificate No._____

_____ Subscriber No._____

City State Zip

(____)_____

Phone

If you have Medical Insurance, it is necessary to have your signature on file. Please provide the information requested above and sign at the bottom of the page.

I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by Insurance.

_____ _____

Signature Date

TEST, PATIENT

"STAYING HEALTHY" ASSESSMENT

Adults, 18 years of age and older

Patient Stamp

Patient Number | Plan Name/Number

If patient stamp not used, write in Patient and Plan Name/Number

Patient's name (first, last)	Date of birth	Sex	Today's date	For Clinical Use
				Assistance needed: Reading: ☐ Yes ☐ No; Interpreter: ☐ Yes ☐ No

You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (✓) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.

Annual Review Date/Initials

					Interventions Code/Date/Initials
	Sample Question and Answers Do you play sports?	Yes	No	Skip	
	Do You:				
1.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip	
2.	See the dentist at least once a year?	Yes	No	Skip	
3.	Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip	
4.	Eat at least 5 servings of fruits or vegetables each day?	Yes	No	Skip	
5.	Try to limit the amount of fried or fast foods that you eat?	Yes	No	Skip	
6.	Exercise or do moderate physical activity such as walking or gardening 5 days a week?	Yes	No	Skip	
7.	Think you need to lose or gain weight?	No	Yes	Skip	
8.	Often feel sad, down, or hopeless?	No	Yes	Skip	
9.	Have friends or family members that smoke in your home?	No	Yes	Skip	
10.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	

Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials RE: Referral FU: Follow-up Needed SP: See Progress Notes