YOUR NAME:_____

FAMILY PRACTICE/INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

_____

Other concerns:

_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY REACTION

1._____
2._____
3._____

_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins, NSAIDs and inhalers.

DRUG NAME STRENGTH FREQUENCY TAKEN

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

IMMUNIZATION HISTORY

- ☐ Chickenpox Date:_____
- ☐ Flu Shot Date:_____
- ☐ Gardasil/HPV Date:_____
- ☐ Hepatitis A Date:_____
- ☐ Hepatitis B Date:_____
- ☐ Meningococcus Date:_____

Immunizations and most recent date:

- ☐ MMR (*Measles, Mumps, Rubella*) Date:_____
- ☐ Pneumonia Date:_____
- ☐ Tdap (*Tetanus and pertussis*) Date:_____
- ☐ Tetanus Date:_____
- ☐ Zostavax (*Shingles*) Date:_____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal
Last Mammogram Date _____ ☐ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause:
_____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____

- ☐ Cesarean sections If yes, then number: _____
- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active

Current sexual partner is ☐ Female ☐ Male
Do you use condoms? ☐ Yes ☐ No
Other Birth control method used:_____

- ☐ Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other (please explain below)

_____

_____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR
1.		
2.		
3.		
4.		

ANY HOSPITAL OR ER VISITS?_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS SUCH AS DEPRESSION, CANCER, DIABETES, HEART DISEASE, OSTEOPOROSIS, STROKE
Grandmother (maternal)	Y/N	____	_____
Grandfather (maternal)	Y/N	____	_____
Grandmother (paternal)	Y/N	____	_____
Grandfather (paternal)	Y/N	____	_____
Father	Y/N	____	_____
Mother	Y/N	____	_____
Brother/Sister	Y/N	____	_____
Brother/Sister	Y/N	____	_____
Other:_____	Y/N	____	_____

SOCIAL HISTORY

OCCUPATION_____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level ☐ None (No exercise) ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

# of cups/cans per day? _____

Alcohol Do you drink alcohol?

☐ Yes ☐ No

If so, how often?

☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week

How many drinks per week? __

Tobacco Do you use tobacco? ☐ Yes ☐ No

If not currently, did you ever use tobacco?

☐ Yes ☐ No

☐ Cigarettes - _____pks./day ☐ Chew - _____/day ☐ Cigars - _____/day ☐ # of years_____

Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No

If yes, list:

_____

_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest heaviness/ Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/ Hunger/Urination
- ☐ Difficulty getting pregnant

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam: _____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent colds/sinus infections
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control
- ☐ Erectile dysfunction

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands
- ☐ Anemia

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Fracture Type_____
- ☐ Fall or Imbalance
- ☐ Use of assist device

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems
- ☐ History of addiction

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

Patient, Parent, or Guardian Signature:_____

Date:_____

Los Alamitos
Family Health & Wellness
caring solutions to enhance every aspect of your life

These questions are designed to help us better understand you as both a person and patient. Please asnswer as many questions as you fell comfortable.

1. Please comment on you CHILDHOOD (Stress or Trauma?Stable and nurturing?)

2. What are KEY FACTORS that you believe affect your health in a positive or negative way (Stress, Sleep, Diet, Drug Side effects, Genetics, Enviromental)?

3. Do you have emotional SUPPORT and feel socially connected?

4. Do you have any ADDICTIONS (alcohol, cigarettes, drugs, food, caffeine, Smart phone, Work, gambling, sex)?

5. What do you do for fun and stress relief?

6. Our Office sells Nutritional products in cases where we feel our patients would benefit. Do you want to hear about natural therapies and nutritional supplements sold in the office?

7. Would you like to receive Facebook updates for continuing Education

(you must "Like" our FB page at Los Alamitos Family Health and Wellness)

Or do you prefer email updates? Please provide email

Los Alamitos Family Health & Wellness
Dr. Jennifer Kim Loomis
3851 Katella Ave Suite 275
Los Alamitos, CA 90720

WELCOME, please tell us about yourself. **Referred by:** _____

Last Name: _____ Suffix: _____ First Name: _____
Middle Name: _____ Nickname: _____
Address: _____ Apt: _____ City: _____
State: _____ Zip: _____
Phones Home: _____ Work: _____
Cell: _____ Fax: _____
Preferred Number: _____ E-Mail Address: _____
How do you want to receive messages and test results: _____

Date of Birth: _____ Gender: _____ Marital Status: _____
Social Security Number: _____
Spouse Name: _____ Phone: _____
Spouse Birth Date: _____ Alternate Phone: _____
Who can we contact in case of an emergency? (If it is the same as your spouse you can leave this blank):
_____ What is their relationship to you?: _____
Phone: _____ Alternative Phone: _____

Are you employed?: _____ Where?: _____
Address: _____

We have the ability to transmit prescriptions to your pharmacy electronically if they participate in E RX.
What is your pharmacy name?: _____ Phone: _____
Is this a mail order pharmacy?: _____ Did they give you a fax form?: _____

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Patient Responsibility Agreement

At the office of Dr. Kim Loomis, We Promise to serve you with respect, care and access to the best medical information and attention possible. Any strong relationship involves mutual respect and open communication and we hope to evoke this king of relationship with our patients.

1. We don't believe in "No news is good news"
   We encourage patients to take advantage of the patient portal to view results, and to follow up if extensive testing has been performed. Interpretation of any test results are best had by a thoughtful discussion with Dr. Loomis in the office.
2. No show Fee/Copays
   We understand there will be cases where appointments are missed. Our Policy requires 24 hour advance notice for cancellations. We reserve the right to charge a fee of $20.00 for missed weekday appointment and $40.00 for missed Saturday appointments that are not canceled within a 24 hour notice. Copays are due at the time of service.
3. Know your insurance
   We will bill your insurance at the time of service. Please keep the office informed of any changesto your insurance plan. We recognize individuals often make self-care decisions based on their access to insurance or "what's covered". We encourage you to communicate with us as Dr. Loomis primary goal is to ensure your best outcome. We offer transparent cash prices for those without insurance or for treatments which insurance does not cover.
4. Acknowledgement of "Abuse free zone"
   At Los Alamitos Family Health and Wellness, We appreciate and respect our Staff. It is our belief that our staff should have an environmental free from verbal abuse. Outbursts against our staff will not be tolerated. We welcome any constructive feedback in the form of an email, phone call, or use of our office Comment Box. We strive to improve our services and our relationships with you.

I have read the above and understand and accept the Patient Responsibility Agreement.

_____
Print Name

_____
Sign

_____
Date

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Insurance Disclaimer

I understand as the patient it is my responsibility to provide the correct insurance information at the time of my appointment. If for any reason my insurance information changes at any time I will be responsible to notify Dr. Jennifer Kim Loomis's Office prior to any upcoming appointments. If the correct insurance information is not on file Dr. Jennifer Kim Loomis reserves the right to bill you the patient as the responsible party.

Sign:_____Date:_____

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan to Los Alamitos Family Health and Wellness.

I understand that I am financially responsible for all charges, including but not limited to copayments and annual deductibles. I hereby authorize said assignee to release all information to secure payment. I hereby consent to and authorize all treatment and medical services by the physician and staff of this office, as they deem necessary. I authorize the release of any information to my insurance company regarding my history, treatment, findings, xrays findings and other clinical studies and diagnosis that this office deems necessary. In order for Dr. Kim Loomis to receive payment from my insurance company.

Sign:_____Date:_____

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Authorization to Communicate Patients

Medical Information

Patient Identification

Name:_____

Date Of Birth:_____

SSN:_____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, Indicate what kinds of information may be shared with each individual. Options are **ALL INFORMATION, SCHEDULING/APPTS, MEDICAL, AND BILLING/INSURANCE.**

Name	Relationship to Patient	Type of Information to Disclose
1.		
2.		
3.		
4.		
5.		

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designation above.

Patient Signature:_____ Date:_____