



Magnolia Plaza

299 W. Foothill #209  
Upland, CA 91786

Ph: (909) 982-4000  
Fax: (909) 981-7800

Dear \_\_\_\_\_

Date \_\_\_\_\_

**Welcome to Women's View Medical Group**

**Your appointment date is: \_\_\_\_\_.**

**Make note of the following:**

- **Arrive 15 minutes early to your appointment**
- **Bring Insurance Card**
- **Current photo ID**
- **Co-Pay ( if it applies)**
- **New patient packet needs to be filled out to its entirety; otherwise your appointment will be rescheduled.**
- **Be prepared to have your picture taken upon arrival**

**We do not accept check, only Credit Card/Debit/Cash**

**There will be a \$25.00 cancellation fee if not cancelled within 24 hours.**



# PATIENT INFORMATION SHEET

## PERSONAL INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Can we leave a message \_\_\_\_ Yes \_\_\_\_ No

Cell Phone: ( ) \_\_\_\_\_ Can We leave a Message \_\_\_\_ Yes \_\_\_\_ No

Birth Date: \_\_\_\_\_ Sex: M F Marital Status S M W D Race: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Do you have an Advance Directive: Yes \_\_\_\_\_ No \_\_\_\_\_

Would you like to sign up for our Patient Portal to view your visit: Yes \_\_\_ No \_\_\_ e-mail address: \_\_\_\_\_

## EMERGENCY CONTACT

Spouse's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Closest Relative: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## INSURANCE INFORMATION

### *PRIMARY INSURANCE*

Insurance Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

### *SECONDARY INSURANCE*

Insurance Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I understand that if the above is not true, or if I am ineligible under the terms of my health plan and/or employer's group's Medical and Hospital Subscriber Agreement, I am financially responsible for all charges for services rendered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# HEALTH QUESTIONNAIRE

NAME: \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**HISTORY OF PAST ILLNESS:** Have you had

Childhood

Measles.....	No	Yes	Rheumatic fever or heart disease.....	No	Yes
Mumps.....	No	Yes	Tuberculosis.....	No	Yes
Chickenpox.....	No	Yes	Venereal disease.....	No	Yes
Diabetes.....	No	Yes	Congenital Abnormalities.....	No	Yes
Strokes.....	No	Yes	Other serious diseases.....	No	Yes
Cancer.....	No	Yes			

Adult:

Have you had a serious illness?..... No Yes  
 Have you ever been hospitalized or been under medical care for very long?..... No Yes  
 If yes, for what reason? \_\_\_\_\_

Operations:

Have you had any surgery?..... No Yes

Injuries:

Have you had any broken bones?..... No Yes  
 Have you had any head concussions or injuries?..... No Yes  
 Have you ever been knocked unconscious?..... No Yes

FAMILY HISTORY	If Living:		If Deceased		Has any blood relative ever had?			
	Age	Health	Age (at death) & Cause					
Father					Cancer	Yes	Who	What type
Mother					Tuberculosis	Yes	Who	What type
Brother/Sister					Diabetes	Yes	Who	What type
					Heart Trouble	Yes	Who	What type
					High Blood Pressure	Yes	Who	What type
Husband/Wife					Stroke	Yes	Who	What type
Son/Daughter					Convulsions	Yes	Who	What type
					Suicide	Yes	Who	What type
					Insanity	Yes	Who	What type
					Bleeding tendency	Yes	Who	What type
					Gout or other arthritis	Yes	Who	What type

SOCIAL HISTORY:

Circle One:    Single    Married    Separated    Divorced    Widowed

Are you living with your husband or wife?..... No Yes  
 Is your sex life satisfactory?..... No Yes  
 Do you have dependents at home?..... No Yes  
 Alcoholic Beverages: \_\_\_ Never \_\_\_ Rarely \_\_\_ Moderately \_\_\_ Daily \_\_\_ Ever..... No Yes  
 Tobacco: \_\_\_ Cigarettes \_\_\_ Packs a day \_\_\_ Don't Smoke \_\_\_ Ever Smoked..... No Yes  
 Are you employed? \_\_\_\_\_ Full time \_\_\_\_\_ Part time  
 What is your job? \_\_\_\_\_  
 Are you exposed to fumes, dust or solvents? \_\_\_\_\_

Education

Grade School	_____ (Years)
High School	_____
College	_____
Postgraduate	_____

How much time have you lost from work because of your health during the past?

Six Month \_\_\_\_\_  
 One Year \_\_\_\_\_  
 Five Years \_\_\_\_\_

SYSTEMIC REVIEW: Do you have any of the following?

General:  
 Recent weight change..... No Yes  
 Have you been in good general health most of your life No Yes

Skin:  
 Skin Disease..... No Yes  
 Jaundice..... No Yes  
 Hives, eczema or rash..... No Yes  
 Frequent infection or boils..... No Yes  
 Abnormal pigmentation..... No Yes

Head-Eyes-Ears-Nose-Throat  
 Eye disease or injury..... No Yes  
 Do you wear glasses?..... No Yes  
 Double vision..... No Yes  
 Headaches..... No Yes  
 Glaucoma..... No Yes  
 Itching eyes or nose..... No Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Sneezing or runny nose..... No Yes  
 Nose Bleeds..... No Yes  
 Chronic sinus trouble..... No Yes  
 Ear Disease..... No Yes  
 Impaired Hearing..... No Yes  
 Dizziness or transient episodes or unconsciousness..... No Yes

Neck:

Stiffness..... No Yes  
 Thyroid trouble..... No Yes  
 Enlarged glands..... No Yes

Respiratory

URI (cold) now..... No Yes  
 Spitting up blood..... No Yes  
 Chronic or frequent cough..... No Yes

**SYSTEMIC REVIEW:**

Respiratory Cont'd

Asthma or Wheezing ..... No Yes  
 Difficulty breathing ..... No Yes  
 Any trouble with lungs ..... No Yes  
 Pleurisy or Pneumonia ..... No Yes

Cardiovascular:

Chest pain or angina pectoris ..... No Yes  
 Shortness of breath with walking or lying down ..... No Yes  
 Difficulty walking two blocks ..... No Yes  
 Heart Trouble or heart attacks ..... No Yes  
 High blood pressure ..... No Yes  
 Swelling of hands, feet or ankles ..... No Yes  
 Awakening in the night smothering ..... No Yes  
 Heart murmur ..... No Yes

Gastrointestinal:

Peptic Ulcer (stomach or duodenal) ..... No Yes  
 Vomiting blood or food ..... No Yes  
 Gallbladder disease ..... No Yes  
 Liver trouble ..... No Yes  
 Hepatitis ..... No Yes  
 Painful bowel movements ..... No Yes  
 Bleeding with bowel movements ..... No Yes  
 Black stools ..... No Yes  
 Hemorrhoids or piles ..... No Yes  
 Recent change in bowel habits ..... No Yes  
 Frequent diarrhea ..... No Yes  
 Heartburn or indigestion ..... No Yes  
 Cramping or pain in the abdomen ..... No Yes  
 Does food stick in throat ..... No Yes

Genitourinary:

Loss of urine ..... No Yes  
 Frequent urination ..... No Yes  
 Night time urination ..... No Yes  
 Burning or painful urination ..... No Yes  
 Blood in urine ..... No Yes  
 Kidney trouble ..... No Yes  
 Kidney stones ..... No Yes

Gynecological:

Age periods started \_\_\_\_\_  
 How long do periods last? \_\_\_\_\_ Days

Gynecological (Cont'd)

Number of pregnancies ..... No Yes  
 Number of miscarriages ..... No Yes  
 Date of last cancer smear and results \_\_\_\_\_  
 Frequency of periods, every \_\_\_\_\_ days.  
 Any pain with your periods ..... No Yes  
 Number of children \_\_\_\_\_ Ages \_\_\_\_\_  
 Date of first day of last period \_\_\_\_\_

Locomotor-Musculoskeletal:

Varicose Veins ..... No Yes  
 Weakness of muscles or joints ..... No Yes  
 Any difficulty in walking ..... No Yes  
 Any pain in calves or buttocks on walking relieved by rest ..... No Yes

Neuro-Psychiatric:

Have you ever had psychiatric care? ..... No Yes  
 Have you been advised to see a psychiatrist? ..... No Yes  
 Do you ever have, or have had, fainting spells? ..... No Yes  
 Convulsions ..... No Yes  
 Paralysis ..... No Yes

Hematologic:

Are you slow to heal after cuts ..... No Yes  
 Blood disease ..... No Yes  
 Anemia ..... No Yes  
 Phlebitis ..... No Yes  
 Have you had difficulty with bleeding excessively after tooth extraction or surgery? ..... No Yes  
 Have you had abnormal bruising or bleeding? ..... No Yes

Allergic:

Any allergies, including medication ..... No Yes

Endocrine:

Thyroid disease ..... No Yes  
 Hormone therapy ..... No Yes  
 Any change in hat or glove size ..... No Yes  
 Any change in hair growth ..... No Yes  
 Have you become colder than before- or skin become drier ..... No Yes

HEIGHT \_\_\_\_\_

WEIGHT \_\_\_\_\_

Date of last tetanus \_\_\_\_\_

**ALLERGIES AND SENSITIVITIES**

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Circle One		What Drug or Food?
Penicillin or other antibiotics ..... Yes	No	Don't know	_____
Morphine, Codeine, Demerol or other narcotics ..... Yes	No	Don't know	_____
Aspirin, emiprin or other pain remedies ..... Yes	No	Don't know	_____
Sulfa drugs ..... Yes	No	Don't know	_____
Tetanus antitoxin or other serums ..... Yes	No	Don't know	_____
Adhesive tape ..... Yes	No	Don't know	_____
Iodine or merthiolate ..... Yes	No	Don't know	_____
Any other drug or medication ..... Yes	No	Don't know	_____
Any foods, such as egg, milk or chocolate ..... Yes	No	Don't know	_____

2. Drugs Recently Taken: Within the past six months has patient taken

Cortisone ..... Yes	No	Don't know
ACTH ..... Yes	No	Don't know
Anticoagulants ..... Yes	No	Don't know
Tranquilizers ..... Yes	No	Don't know
Hypotensives (high blood pressure medicines) ..... Yes	No	Don't know
Has the patient ever received treatment for:		
Asthma, rheumatism or rheumatic fever? ..... Yes	No	Don't know
Aspirin ..... Yes	No	Don't know

Source of information, if other than patient: \_\_\_\_\_

Signature of person acquiring this information: \_\_\_\_\_

Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

# RX History Consent

## WOMEN'S VIEW MEDICAL GROUP

Date \_\_\_\_\_

By signing below I authorize Women's View Medical Group to

obtain my pharmaceutical history through electronic medical records.

\_\_\_\_\_  
Signature

# AUTHORIZATION FOR RELEASE OF INFORMATION

## SECTION A: Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Person(s)/organizations authorized to use/disclose information (from): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person(s)/organizations authorized to receive the information: \_\_\_\_\_

**Women's View Medical Group**  
**299 W. Foothill Blvd., #209**  
**Upland, CA 91786**

Information that may be used/disclosed:

(Include dates where appropriate, e.g., medications dispensed in December 2002 or EKG Report performed in June 2000)

- |  |   |
|--|---|
| <input type="checkbox"/> Record of Visits (all) _____        | <input type="checkbox"/> Laboratory Report(s) _____                       |
| <input type="checkbox"/> Record of Visit(s) (Specific) _____ | <input type="checkbox"/> X-Ray, MRI, CT _____                             |
| <input type="checkbox"/> Discharge Summary _____             | <input type="checkbox"/> Echo, Stress Tests, Holters _____                |
| <input type="checkbox"/> History/Physical _____              | <input type="checkbox"/> EKG Report _____                                 |
| <input type="checkbox"/> Consultation Report(s) _____        | <input type="checkbox"/> Mental Health/Alcohol/Drug Abuse Treatment _____ |
| <input type="checkbox"/> Operative Report(s) _____           | <input type="checkbox"/> AIDS or HIV Information _____                    |
| <input type="checkbox"/> Problem List _____                  | <input type="checkbox"/> Hepatitis Information _____                      |
| <input type="checkbox"/> Progress Notes _____                | <input type="checkbox"/> Entire Medical Record _____                      |
| <input type="checkbox"/> Immunization Record(s) _____        | <input type="checkbox"/> Statement of Charges/Payments _____              |
| <input type="checkbox"/> Medication Record(s) _____          | <input type="checkbox"/> Other _____                                      |

## SECTION B: Must be completed only if a health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

a. The information will be used/disclosed for the following purposes:

- |   |  |
|---|--|
| <input type="checkbox"/> Continued Patient Care   | <input type="checkbox"/> Attorney/Legal  |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Insurance Claim |
| <input type="checkbox"/> Personal Use             | <input type="checkbox"/> Other _____     |

b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes \_\_\_\_\_ No \_\_\_\_\_

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

3. I understand that I may inspect and copy any information to be used or disclosed.

## SECTION C: Must be completed for all authorizations.

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires \_\_\_\_\_  
(Insert applicable date or event that triggers expiration)

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Printed Name of Patient's Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient



RECEIPT OF NOTICE OF PRIVACY  
PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

WOMEN'S VIEW MEDICAL GROUP

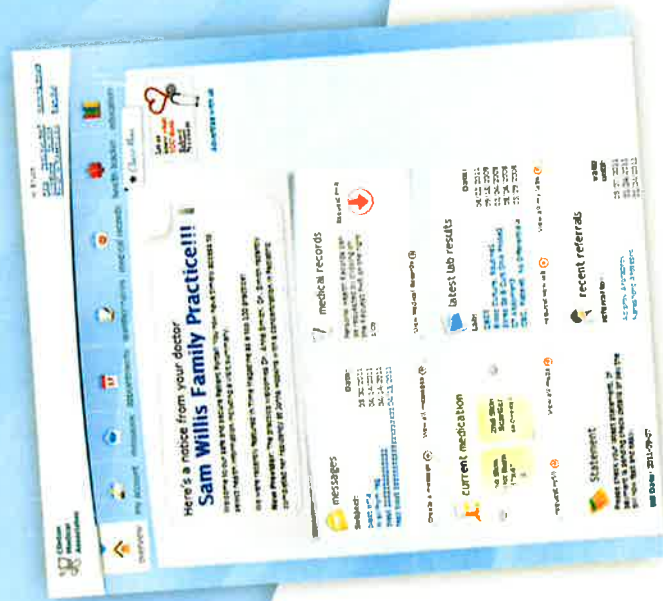
I, \_\_\_\_\_ ( Patient ) have read a copy of  
Women's View Medical Group's Notice of Patient Privacy Practices

\_\_\_\_\_  
Signature of Patient, Parent or legal Guardian

\_\_\_\_\_  
Date

Access your own personal  
Patient Portal online.

what is  
**Patient Portal**



Know your health...  
...Know yourself



<http://www.eclinicalworks.com/products-patient-portal.htm>





what are my

## Patient Benefits

how do I

## Get Web-Enabled

### This Practice

is now offering our patients easy and private access to their medical information online, so you can view your personal health record whenever and wherever you have access to the Internet!

Gain access to your private health information and receive periodic updates and reminders from your doctor on your personal e-mail address!

With Patient Portal, you will have access to:



#### Appointments

Book and keep track of appointments



#### Lab Results

Access and view lab results



#### Medication

Request prescription refills



#### Medical Records

View your personal health record



#### Education

Receive educational materials



#### Messages

Send & receive messages from staff



#### Reminders

Receive health reminders



#### Billing

View & pay billing statements



#### Demographic Information

Update demographic information



#### Referrals

View & request referrals

To gain access to our secure server on Patient Portal and become web-enabled, simply sign up by providing us with a personal (non-work) e-mail address.

You will be able to securely log in with your username and password, and gain access to your personal health record and other helpful features from any computer or smartphone with an Internet connection!