Physical Exam / Well Women Pap Smear Waiver and Protocol

SouthCoast
MEDICAL GROUP
Family Care ✚ Urgent Care
Sports Care

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Executive Director

Dear Patient,

It is our understanding that you are scheduled for an annual preventative screening or a well women exam at South Coast Medical Group. Due to the various insurance plans and coverage types, we'd like to advise you of our basic protocols for these exams. Procedures are based on your age and health history. (See below) It's important that you contact your insurance company to be sure these procedures are covered under your policy. Please note that an annual physical exam and an annual pap smear are two different procedures and office visits.

Please note, if you are having immediate medical issues or you have questions about a chronic medical condition you DO NOT have to schedule a physical exam, you are able to discuss these issues with your physician during an office visit. Understand that the time allotted for your complete annual screening and or well women exam is to address your health history maintenance and preventative screenings only.

Additionally, South Coast Medical Group does not bill your insurance company for lab/blood work. All billing issues need to be dealt with directly with the lab, not South Coast Medical Group billing department.

Annual Physical:
History and physical exam
Hearing Exam (18 and under)
Vision Exam (18 and Under)
Urine analysis
Ekg
Chest X-ray
Blood Test (Metabolic panel, lipid panel, CBC, thyroid panel, PSA(males), Vitamin D, and hsCRP
Immunizations as indicated

Please note that SCMG NO LONGER draws blood at our office. All blood draws will be sent to the lab.

Well Women Pap Smear:
Pap smear
HPV testing, over the age 30 requested, and if indicated for abnormal results.
GC/Chlamydia if under age 25 or requested
Wet Mount if indicated for vaginal discharge
Referral for mammogram if indicated

See Page 2

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Aliso Viejo, California 92656
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www.SouthCoastMedGroup.com

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Understanding Healthcare Reform and How it Relates to Your Benefits

Due to misunderstandings about health care reform, we'd like you to take a minute and call your insurance company to verify what annual preventative coverage you have. An annual physical is a preventative screening exam. If you are having any ailment such as lower back pain, headaches, stomach aches, etc…this would be a separate "sick" visit and NOT PART of your annual screening. If the ailment is simple enough, the SCMG medical provider will treat BUT a separate co-pay for the office visit will apply.

If a more or prominent issue arises during your annual preventative screening other than preventative needs; our office will accommodate you by addressing your current issues and rescheduling your annual preventative screening. The physician will treat and examine you for your illness or prevailing condition if they are more pressing.

My signature below indicates that I understand that it is my responsibility to know my insurance coverage. Furthermore, I understand that all services are my financial responsibility.

_____
Patient Name:

_____ _____
Patient Signature Date

*****Please note that SCMG is open Monday through Friday 8am to 5pm (General Walk-In) 5pm to 7p (Urgent Care), Saturdays 9am to 3pm (Urgent Care) and 10am to 3pm (Urgent Care). No appointment necessary to treat your acute or chronic illness.**

In the event that your forms (New Patient or established update, health history, well women Questionnaire, and Physical / Well Women Waiver) are not filled out before coming in to your scheduled appointment, we will need to reschedule your appointment for a later date.

All Scheduled Appointment Not Cancelled Within 24 Hours are Subject to a $25 No-Show Fee.

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HEALTH QUESTIONNAIRE

Name _____ Birthdate _____ Date _____

Last Date of Physical Exam Month_____ Year _____ Last Pap Smear Month_____ Year _____
Last Date of Colonoscopy Month_____ Year _____ Last Tetanus Shot Month_____ Year _____
Last Date of Mammogram Month_____ Year _____

DRUG ALLERGIES

CURRENT MEDICATIONS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding disorder						
Kidney Disease						
Thyroid disease						
Mental Illness						
Osteoporosis						

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY Pregnant? ❒ YES ❒ NO Planning Pregnancy? ❒ YES ❒ NO

PAST MEDICAL HISTORY

- ❒ Migraines
- ❒ High blood pressure
- ❒ Heart Arrhythmia
- ❒ Heart murmur
- ❒ Heart Attack
- ❒ High Cholesterol
- ❒ Peripheral vascular disease
- ❒ Allergies/Hay fever
- ❒ Asthma
- ❒ Bronchitis
- ❒ Pneumonia
- ❒ Ulcer
- ❒ GI disorder
- ❒ Lactose Intolerance
- ❒ Gall bladder disease
- ❒ Prostate disease
- ❒ Incontinence
- ❒ Sexual/Menstrual dysfunction
- ❒ Sexually Transmitted Disease
- ❒ Hepatitis
- ❒ Anemia
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Gout
- ❒ Anxiety
- ❒ Depression
- ❒ Thyroid disease
- ❒ Diabetes Type I ❒ Type II ❒
- ❒ Last A1C blood test _____
- ❒ Chronic rashes
- ❒ Cancer_____type
- ❒ Sleep Apnea
- ❒ A.D.D.
- ❒ Other _____

HABITS

❒ Smoke: Packs daily _____ *How long?* *When stopped?*
❒ Coffee: Cups daily? _____ *Other caffeines?* Diet: Salt intake
❒ Exercise routine: _____ Fat intake
❒ Alcohol: Type/Amount _____
❒ SLEEP: Difficulty falling asleep ❒ Snoring ❒ Daytime drowsiness ❒ Continuity disturbances ❒ Early morning awakening ❒

Sleep Disorder Questionnaire

Patient Name: _____ Height: _____

Email: _____ Weight: _____

Gender: M F BMI: _____ DOB: _____ Neck Size: _____

Please circle answer:

Do you snore:	None	Soft	Moderate	Loud	Disruptive

Snoring can be heard outside of the bedroom	Yes	No
Snoring is present only when sleeping on back?	Yes	No
Do you have unexplained awakenings from sleep?	Yes	No
Do you awaken from sleep gasping for air or choking?	Yes	No
Do you notice frequent twitching or jerking of legs while asleep?	Yes	No
Do you lack energy upon waking in the morning?	Yes	No
Do you have a headache upon waking in the morning?	Yes	No
Do you often lay in bed unable to fall asleep?	Yes	No
Do you wake up during the night and are unable to fall back asleep?	Yes	No
Do you find it difficult to stay awake during the day?	Yes	No

*****If you have answered YES to any one of the above questions please consult with your doctor*****

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

0 = Would never doze 1 = Slight chance of dozing

2 = Moderate chance of dozing 3 = High chance of dozing

Sitting and reading	_____
Watching T.V.	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score	_____

*****If your Epworth score is 10 or greater please consult with your doctor*****

Physician Name: _____

Phone: _____ Fax: _____

Sleep Questionnaire Provided By REM Sleep Labs (888) 866-1211

Rev 02/27/09