ANNUAL HEALTH QUESTIONNAIRE AGE 65 AND OVER

Name ____________________________ Birthdate_____________ Date_________________

Married ____ Single____ Divorced____ Widow____ Partnered_____

Do you live alone? ___Yes ___No If no, please specify who lives with you ____________________

Do you have a caregiver? ___Yes ___No

Do you live in a: ____House ____Apartment ____Senior Living Community ____Skilled Nursing Facility

Did you drive yourself to the office today? ___Yes ___No If no, please specify how you arrived today ________

Have you completed an Advanced Directive? ___Yes ___No

If YES, do we have one on file. ___Yes ___No (Please note, Medicare requires your Primary Care Physician to have a copy on file.)

HEALTH MAINTENANCE	
Last Date of Physical Exam Month_____Year_____	Last Date of Tetanus Vaccine Month_____Year_____
Last Date of Colorectal Cancer Screen Month____Year____	Last Date of Flu Vaccine Month_____Year_____
Last Date of Mammogram Month_____Year_____	Last Date of Pneumonia Vaccine Month_____Year_____
Last Date of PAP Smear Month_____Year_____	Last Date of Eye Exam Month_____Year_____

DRUG ALLERGIES

CURRENT MEDICATIONS

FAMILY HISTORY			
Diagnosis	**Father**	**Mother**	**Siblings**
Heart Disease			
High Blood Pressure			
Stroke			
Cancer			
Glaucoma			
Diabetes			
Epilepsy			
Bleeding Disorder			
Kidney Disease			
Thyroid Disease			
Mental Illness			
Osteoporosis			

HOSPITALIZATION OR SURGERY			
Reason:	Date:	Reason:	Date:

PAST MEDICAL HISTORY

- □ A.D.D.
- □ Allergies/hay fever
- □ Anemia
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Benign prostatic hypertrophy/enlarged prostate
- □ Breast cancer
- □ Breathing problems caused by emphysema or asthma
- □ Bronchitis
- □ Cancer ________ type
- □ Depression
- □ Diabetes Type I_____ Type II_____
  Last A1C results ____
- □ Gall bladder disease
- □ Gout
- □ Heart arrhythmia
- □ Heart attack
- □ Heart disease
- □ Heart failure or an enlarged heart
- □ Heart murmur
- □ Hepatitis
- □ High cholesterol
- □ Hypertension/high blood pressure
- □ Incontinence
- □ Kidney disease
- □ Lactose intolerant
- □ Migraines
- □ Osteoporosis
- □ Other GI disorder
- □ Peripheral vascular disease
- □ Pneumonia
- □ Prostate cancer
- □ Sexual dysfunction
- □ Sexually transmitted disease
- □ Sleep apnea
- □ Stomach ulcer
- □ Thyroid disease
- □ Other ____________________

HABITS	
Smoke: Packs daily _____ How long_____ When stopped_____	Diet: Salt intake ______ Fat intake ______
Coffee: Cups daily _____ Other caffeine_______	Exercise: What_____ Length_____ How often_____
Alcohol: Type____________ Amount___________	Other recreational activities_______

SELF ASSESSMENT QUESTIONNAIRE

Have you experienced any recent weight change? ____Weight gain ____Weight loss ____No change

Question	Always	Sometimes	Never
Do you wear dentures?			
Do you have any problems hearing?			
Do you wear hearing aid(s)?			
Do you have problems with vision?			
Do you wear contacts/glasses?			
Do you have pain?			
If yes, where________________ ; rate on a scale of 1-10 (least-most severe)__________________			
Are you able to do your own grocery shopping?			
Are you able to prepare your own meals?			
Are you able to groom yourself daily?			
Are you able to use the restroom by yourself?			
Do you have any difficulty ambulating?			
Do you think you are at high risk of falling?			
Do you have any problems/concerns with your memory?			
Are you able to recall recent events?			
Are you able to recall past events?			
Do you ever feel confused or lost?			
Have you or others noticed inappropriate behavior in your actions?			
Do you have any recent major stress in your life?			
Do you feel down or depressed?			
Do you have any difficulty sleeping?			
Do you think you are at risk of admission to a hospital?			
Do you think you should be living at a skilled nursing facility?			
Can you organize and take your medication by yourself?			
Please indicate the number of over the counter medication being taken each day or answer 0 for None ____________			

SELF PLAN AND FUTURE GOALS

____

____

____

____

Physical Exam / Well Women Pap Smear Waiver and Protocol

SouthCoast
MEDICAL GROUP
Family Care + Urgent Care
Sports Care

John Cheng, M.D., F.A.A.F.P.
Medical Director
Diplomate, American Board of Family Medicine
Fellowship, Sports Medicine
Urgent Care/Occupational Medicine

Shannon O'Connor, M.D., F.A.A.F.P.
Diplomate, American Board of Family Medicine
Urgent Care/Occupational Medicine

Archana Bhogill, M.D., F.A.A.F.P.
Diplomate, American Board of Family Medicine
Urgent Care/Occupational Medicine

Eric Clark, M.D., F.A.A.F.P.
Diplomate, American Board of Family Medicine
Urgent Care/Occupational Medicine

Tyler Tran, PA-C
Family and Sports Medicine

Shawn Brewster, PA-C
Family and Urgent Care

Chardonnay Shinn, PA-C
Family and Urgent Care

Johnna Gherardini, B.S.B.A., R.T.
Executive Director

5 Journey, Suite 130
Aliso Viejo, California 92656
949-360-1069
FAX 949-389-8968

www.SouthCoastMedGroup.com

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

SouthCoast
MEDICAL GROUP
Family Care Urgent Care
Sports Care

John Cheng, M.D., F.A.A.F.P.
Medical Director
Diplomate, American Board of Family Medicine
Fellowship, Sports Medicine
Urgent Care/Occupational Medicine

Shannon O'Connor, M.D., F.A.A.F.P.
Diplomate, American Board of Family Medicine
Urgent Care/Occupational Medicine

Archana Bhogill, M.D., F.A.A.F.P.
Diplomate, American Board of Family Medicine
Urgent Care/Occupational Medicine

Eric Clark, M.D., F.A.A.F.P.
Diplomate, American Board of Family Medicine
Urgent Care/Occupational Medicine

Tyler Tran, PA-C
Family and Sports Medicine

Shawn Brewster, PA-C
Family and Urgent Care

Chardonnay Shinn, PA-C
Family and Urgent Care

Johnna Gherardini, B.S.B.A., R.T.
Executive Director

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.

5 Journey, Suite 130
Aliso Viejo, California 92656
949-360-1069
FAX 949-389-8968

www.SouthCoastMedGroup.com

Sleep Disorder Questionnaire

Patient Name: ____

DOB: ____________________ Gender: ☐ M ☐ F Height: ___________ Weight: ___________ BMI: _______

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: ______________________________