Referring and/or Primary Physician Name & Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Soc Sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex:\_\_\_\_\_\_\_(M)\_\_\_\_\_\_\_(F) Marital Status: (M) Married (S) Single (W) Widowed (D) Divorced (O) Other

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: (F) Full Time (P) Part Time (R) Retired (N) Not Employed

Student Status (F) Full Time (P) Part Time (N) Not

**~SPOUSE OR LEGAL GUARDIAN OF PATIENT~**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_(M) \_\_\_\_\_\_\_\_\_\_(F)

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Soc Sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE** **SECONDARY INSURANCE**

Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Subscriber Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Soc Sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Soc Sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Sex: \_\_\_\_\_\_(M) \_\_\_\_\_\_(F) Subscriber Sex: \_\_\_\_\_\_(M) \_\_\_\_\_\_(F)

Person to notify in case of emergency (someone not living with you)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELEASE AND ASSIGNMENT: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE HEALTHCARE PROVIDER.. I ALSO AUTHORIZE ANY RELEASE OF INFORMATION BY MY PROVIDER AS REQUIRED BY THE INSURANCE COMPANY FOR THIS ACCOUNT TO BE PAID. RELEASE OF INFORMATION MAY INCLUDE: (1) ALCOHOL AND/OR DRUG ABUSE TREATMENT, (2) PSYCHIATRIC DIAGNOSIS, TREATMENT AND SUMMARIES, (3) TEST RESULTS FOR HUMAN IMMUNODEFICIENCY (HIV), SEXUALLY TRANSMITTED DISEASES (STD), AND THE TREATMENT THEREOF. I HEREBY RELEASE JOHN JOO, DPM AND RAPHA CLINIC FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM DISCLOSURE OF MY RECORDS AS PROVIDED BY THIS PARAGRAPH.

PAYMENT: I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE. I AGREE TO MAKE PAYMENT ARRANGEMENTS; PAY $5 OR 1% INTEREST PER MONTH (WHICHEVER IS GREATER) ON UNPAID BALANCES OVER 60 DAYS AND ALL THE REASONABLE EXPENSES SUCH AS ATTORNEY FEES AND COURT COSTS SHOULD THE ACCOUNT BE REFERRED FOR COLLECTIONS.

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

건강 설문지 (HEALTH QUESTIONNAIRE)

**해당사항에 체크해 주세요.**

체질증상 비뇨생식기

갑작스러운 체중변화가 있다...….…… 예 아니오 소변을 자주 본다….………………….………..….. 예 아니오

열 또는 오한이 있다.…………………………….. 예 아니오 소변을 볼때 통증이 있다……….…..…….. 예 아니오

도한, 열감이 있다.…………..………….………….. 예 아니오 소변을 볼때 피가 나온다..…….……..…… 예 아니오

피로가 심하다..………….……………..……………... 예 아니오 숙면 후 소변을 한번 이상 본다..……. 예 아니오

요실금이 있다……………………………………….. 예 아니오

혈액/림프 소변줄기가 약하다………………………………. 예 아니오

피가 자주나고 멍이 쉽게 든다.……. 예 아니오 신장결석이 있다 ………………………… 예 아니오

빈혈이 심하다.…………….…………………………. 예 아니오

성관계를 가질때 어려움이 있다……. 예 아니오

소변 시작과 멈춤에 어려움이 있다. 예 아니오

눈

사물이 흐리고 여러개로 보인다………... 예 아니오

귀/코/입/목

귀가 잘들리지 않고 울림이 심하다…… 예 아니오

귀에 통증이 있다…..……………………………….…. 예 아니오

비염이 심하다.………………………...…………………. 예 아니오 근골격

코피가 자주난다..…….…………………………….…. 예 아니오 관절에 통증이 있다..…………………….. 예 아니오

잇몸에서 피가 쉽게 난다….……………….… 예 아니오 관절이 경직돼있고 붓는다.….….. 예 아니오

목이 아프고 자주 쉰다..………………………….. 예 아니오 등과 허리에 통증이 있다.………….. 예 아니오

꽃가루 알러지가 있다.……………………………. 예 아니오

피부/유방

심혈관 피부에 발진이 있다….…………………... 예 아니오

심장에 문제가 있다.………………………………… 예 아니오 유방에 통증이 있다.…………….………… 예 아니오

협심증이 있다…………………….………………..…….. 예 아니오 유방종괴가 있다 ………….………….……….. 예 아니오

가슴 두근거림이 심하다..…………………….. 예 아니오 유두분비가 있다.………………………….…… 예 아니오

걷거나 누울시 숨이 찬다..……………………. 예 아니오

발이나 손이 자주 붓는다..……….…………… 예 아니오 신경

고혈압이 있다……….………………………………… 예 아니오 머리가 자주 아프다…………………….… 예 아니오

어지럼증이 심하다…………….………..…. 예 아니오

호흡기관 경련 또는 발작을 일으킨다…...….. 예 아니오

기침이 심하다.………………..………………..………. 예 아니오 손, 발이 저리고 얼얼하다……….……. 예 아니오

피를 토한다..………………………………….…………... 예 아니오 마비가 있다……………………………………..……. 예 아니오

호흡이 짧다.…………………………………….……….… 예 아니오 기억상실증이 있다………..…………………. 예 아니오

천식, 천명이 있다………………………….……….. 예 아니오

내분비

위장 갑상선 질환이 있다.……………….………. 예 아니오

식욕이 없다…..……………………………………….…. 예 아니오 당뇨병이 있다..……………………………..……. 예 아니오

장 움직임에 이상이 느껴진다...…..…. 예 아니오 선천적 호르몬 문제가 있다…. …... 예 아니오

구역질, 구토가 심하다..………………………. 예 아니오

설사를 자주한다..………………………….………... 예 아니오 OTHER

장에 통증이 느껴진다..……………………..…. 예 아니오 신경이 과민하다..……………………….……. 예 아니오

혈변을 본다..………………………………………….…. 예 아니오 우울증이 있다………………..…………………… 예 아니오

복부에 통증이 있고 속이 쓰리다…. 예 아니오 불면증이 있다……………………………………. 예 아니오

소화성 궤양이 있다…………………….……...… 예 아니오

음식을 삼키기가 힘들다…………….……… 예 아니오 외의 다른 증상을 적어주세요:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

의사 이니셜: \_\_\_\_\_\_\_\_\_\_\_\_\_­­\_ 날짜: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH QUESTIONNAIRE (Continued)

**ARE YOU EXPERIENCING ANY OF THE FOLLOWING:**

CONSTITUTIONAL SYMPTOMS GENITOURINARY

Unexplained weight gain or loss ……………. Yes No Frequent urination ……………………………Yes No

Fever or chills ……………………………………….. Yes No Burning or painful urination ……………..Yes No

Night sweats/Hot flashes ………………………. Yes No Blood in urine ……………………………………Yes No

Fatigue ………………………………………………….. Yes No Urination at night (> 1/night)? ………….Yes No

Incontinence or dribbling ………………… Yes No

HEMATOLOGIC/LYMPHATIC Decrease in urine stream ………………… Yes No

Bleeding or bruising tendency ………………. Yes No Kidney stones ………………………………….. Yes No

Anemia …………………………………………………. Yes No

Sexual difficulty ……………………………….. Yes No

Slow to start/stop urination …………….. Yes No

EYES

Blurred or double vision …………………………. Yes No

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing …………………………. Yes No

Earaches or drainage ……………………………. Yes No

Chronic sinus problem or rhinitis …………. Yes No MUSCULOSKELETAL

Recurrent nose bleeds …………………………. Yes No Joint pain ……………………………………….. Yes No

Bleeding gums ……………………………………… Yes No Joint stiffness or swelling ……………….. Yes No

Sore throat or voice change (hoarseness). Yes No Back pain ……………………………………….. Yes No

Hay fever ………………………………………………. Yes No

INTEGUMENTARY (skin, breast)

CARDIOVASCULAR Rash or itching ………………………………... Yes No

Heart trouble ………………………………………… Yes No Breast pain ……………………………………… Yes No

Chest pain or angina pectoris ……………….. Yes No Breast lump …………………………………….. Yes No

Palpitation (fast or irregular heart beat) .. Yes No Breast discharge ……………………………… Yes No

Shortness of breath while walk/lying flat . Yes No

Swelling of feet, ankles or hands …………… Yes No NEUROLOGICAL

High blood pressure ………………………………. Yes No Frequent or recurring headaches …… Yes No

Lightheaded or dizzy ………………………. Yes No

RESPIRATORY Convulsions or seizures ………………….. Yes No

Chronic or frequent coughs ………………….. Yes No Numbness or tingling sensations ……. Yes No

Spitting up blood ………………………………….. Yes No Paralysis …………………………………………. Yes No

Shortness of breath ……………………………… Yes No Memory loss or confusion ………………. Yes No

Asthma or wheezing …………………………….. Yes No

ENDOCRINE

GASTROINTESTINAL Thyroid disease ………………………………. Yes No

Loss of appetite ……………………………………. Yes No Diabetes …………………………………………. Yes No

Change in bowel movements ………………. Yes No Other glandular or hormone problem Yes No

Nausea or vomiting ……………………………… Yes No

Frequent diarrhea ……………………………….. Yes No OTHER

Painful bowel movements or constip……. Yes No Nervousness …………………………………… Yes No

Rectal bleeding or blood in stool …………. Yes No Depression/Anxiety/Panic ……………… Yes No

Abdominal pain or heartburn ………………. Yes No Insomnia ……………………………………….. Yes No

Peptic ulcer (stomach or duodenal) …….. Yes No

Trouble swallowing ……………………………… Yes No Other concerns not noted above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

환자 건강 설문지 이름 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**오늘 방문의 주된 이유** 날짜 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**의료 기록**

심각한 사고 / 병 / 외의 다른 질환(예: 암, 심장병, 고혈압, 폐렴)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

과거 입원, 수술 기록 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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현제 복용중인 약 / 보충제

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

알러지가 있는 약

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**여성:**

임신 횟수\_\_\_\_\_\_\_\_ 유산 횟수\_\_\_\_\_\_\_ 낙태 횟수\_\_\_\_\_\_\_ 첫 월경이 시작된 나이\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

폐경기 나이\_\_\_\_\_\_\_\_ PAP TEST 마지막 검사일 \_\_\_\_\_\_\_\_\_\_\_\_\_ 유방 X선 마지막 촬영일\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**환자 생활 기록**

결혼 여부: 미혼\_\_\_\_\_ 기혼\_\_\_\_\_\_ 별거\_\_\_\_\_\_ 이혼\_\_\_\_\_\_ 과부\_\_\_\_\_\_\_

현재 직업: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 성적 취향 (선택항) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

술: 전혀 마시지 않는다\_\_\_\_\_\_\_\_ 가끔씩 마신다\_\_\_\_\_\_\_\_ 자주 마신다\_\_\_\_\_\_\_\_ 매일 마신다\_\_\_\_\_\_\_\_

카페인 (하루에 몇잔씩 마시는지 기록해 주십시오): 커피\_\_\_\_\_\_\_\_ 음료수\_\_\_\_\_\_\_\_ 차\_\_\_\_\_\_\_\_

담배: 전혀 피우지 않는다\_\_\_\_\_\_\_\_ 과거에 피웠으나 현재 끊었다\_\_\_\_\_\_\_\_\_\_ 현재 피운다 (하루에 몇갑)\_\_\_\_\_\_\_\_

마약: 전혀 해보지 않았다\_\_\_\_\_\_\_\_ 해본 경험이 있다 (종류) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

운동: 전혀 하지 않는다\_\_\_\_\_\_ 가끔씩 한다\_\_\_\_\_\_ 매주 한다\_\_\_\_\_\_ 매일 한다\_\_\_\_\_\_ 운동종류\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**가족 의료 기록** (본인과의 관계를 적으시오)

관절염 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 고혈압 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

천식/알레르기 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 정신 질환 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

암 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 골다공증 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

당뇨 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 조기 폐경 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

유전 장애 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 뇌졸중 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

심장병 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 갑상선 장애 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT HEALTH QUESTIONNAIRE Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please print)

**MAIN REASON FOR TODAY’S VISIT:** Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Serious Injuries / Illnesses / Medical Problems (i.e. cancer, heart disease, high blood pressure, pneumonia)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Previous Hospitalizations and Surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications/Vitamins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Allergies to Medicine (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN ONLY:**

# of pregnancies\_\_\_\_\_\_\_\_ # of miscarriages\_\_\_\_\_\_\_ # of abortions\_\_\_\_\_\_ Age at 1st menstrual cycle?\_\_\_\_\_\_\_\_\_\_\_

Age at menopause\_\_\_\_\_\_\_\_ Last Pap Smear\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT SOCIAL HISTORY**

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_\_\_

Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of Alcohol: Never \_\_\_\_\_\_\_\_ Rarely \_\_\_\_\_\_\_\_ Moderate \_\_\_\_\_\_\_\_ Daily \_\_\_\_\_\_\_\_

Use of Caffeine, Cups per Day: Coffee \_\_\_\_\_\_\_\_ Sodas \_\_\_\_\_\_\_\_ Tea \_\_\_\_\_\_\_\_

Use of Tobacco: Never \_\_\_\_\_\_\_\_ Previously, but quit \_\_\_\_\_\_\_\_\_\_ Current packs/day \_\_\_\_\_\_\_\_

Use of Drugs: Never \_\_\_\_\_\_\_\_ Type/Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise: Never \_\_\_\_\_ Rarely \_\_\_\_\_\_ Weekly \_\_\_\_\_ Daily \_\_\_\_\_\_ Type of Exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY** Do you know of any blood relatives who have or had: (indicate relationship)

Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma/Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Osteoporosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Premature Menopause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

**I wish to be contacted in the following manner (check all that apply):**

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Written Communication

O.K. to leave message w/ detailed info. O.K. to mail to my home address

Leave message with call-back number only O.K. to mail to my work/office add.

O.K. to fax to this number

Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

O.K. to leave message w/detailed info. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leave message w/call-back number only

**Verbal Communication Authorized with (name / relationship) :**

**\*\*Access to your Rapha Clinics electronic medical records is available through the patient portal. Please provide patient or a family member’s current email address:**

**E-Mail address:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

SEATTLE NEPHROLOGY AND ENDOCRINOLOGY

& RAPHA CLINIC

PRIVACY NOTICE

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

**UNDERSTANDING YOUR HEALTH INFORMATION:**

Each time you visit our clinic(s), physicians, or other healthcare providers, a record of your visit is made. This record may contain personal identifying information about you and your health. It will also contain information related to your care. This may include your medical history, results of physical examinations, test results, diagnoses, treatments, instructions provided to you by your healthcare provider and plans for future healthcare services. This information is often referred to as your health or medical record. Your medical record serves as a:

* Record for planning your care and treatment;
* Way to communicate among the many health professionals who provide your care;
* Legal document describing the care you received;
* Resource you or your healthcare insurance company can use to check the accuracy of your bill;
* Tool for educating health professionals;
* Source of information for medical research;
* Source of information for public health officials responsible for improving the health of our nation;
* Source of information for Seattle Nephrology and Endocrinology & Rapha Clinic operations including the development of future plans, marketing our services, assessing the quality of your care and identifying ways to improve our services to you and the community.

Understand what is in your record and how it is used helps you to:

* Make sure it is accurate;
* Better understand who, what, when, where, and why others may use your health information;
* Make decisions about allowing the information to be used by or shared with others.

**“DESIGNATED RECORD SET”**

In addition to your health record, Seattle Nephrology and Endocrinology & Rapha Clinic also maintains financial records and specialized documents, such as x-ray films that are maintained separate from your health record. The combination of these records is referred to as your “Designated Record Set.”

Notice of Privacy Practices

Effective 04/14/2003 1

**YOUR HEALTH INFORMATION RIGHTS:**

The medical record we keep on you is the property of Seattle Nephrology and Endocrinology & Rapha Clinic. However, the information in the record belongs to you and you have a right to:

* Get a copy, read and ask questions about this notice;
* Request that we limit certain uses and releases of your records. You must make that request in writing. We are not required to agree to that request, but we will help you with any request we agree to;
* You may request for and get a paper copy of the most current Notice of Privacy Practices for Protected Health Information;
* Request that you be allowed to see and get a copy of your medical record. You must give us the request in writing and you may be asked to pay a fee to cover the cost of copying. Forms for this purpose are available at our reception desk.
* Request to have us review a denial of access to your medical record. The request may be denied for certain reasons;
* Request corrections to your health records; the request must be given to us in writing. If the request is denied, you may submit a written statement of disagreement that will become part of your medical record and will be included when the related information is used or disclosed.
* Obtain a report of certain disclosures of your health information.
* Request that any or all communications of your health information be made by different means or to a different location. The request must be made in writing.
* Take back any authorization to use or disclose your health information except when the information has already been disclosed.

**OUR RESPONSIBILITIES:**

Seattle Nephrology and Endocrinology & Rapha Clinic is required to:

* Protect the privacy of your health information;
* Provide you with a notice about our legal duties and privacy practices;
* Uphold the terms of this notice;
* Inform you if we do not agree to a requested restriction;
* Respect reasonable requests to communicate health information by different means or to different locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

Notice of Privacy Practices 2

Effective 04/14/2003

**FOR MORE INFORMATION AND TO REPORT A PROBLEM**

**If you have questions or believe your privacy rights have been violated, you may contact our Clinic Manager (Privacy Officer) at 206.542.1000.**

You may also file a complaint with the Region X Office of Civil Rights, U.S. Department of Health & Human Services.

There will be no action taken against you for filing a complaint.

**EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

We may use your health information for treatment: Example:

Information received or recorded by a nurse, medical assistant, physician, mid-level practitioner, or other member of your healthcare team will be in your record and used to plan the course of treatment best suited for you. Your provider will enter in your record any instructions to your healthcare team. Members of your team will review the instructions and record any actions they took and their observations.

We may use your health information for payment purposes: Example:

A bill will be sent to you, or your insurance company (or organizations acting on their behalf) if you have provided written authorization for us to do so. The information we provide to them will identify you, your diagnosis, procedures you may have had and supplies used. A copy of your medical record may be provided to an external review agency working with your insurance company to review services provided and to ensure correct reporting of those services.

We may also use and disclose your protected health information for Seattle Nephrology and Endocrinology & Rapha Clinic. Example:

We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also use and disclose your information to conduct or arrange for services, including

* Medical quality review;
* Accounting, legal, risk management, and insurance services;
* Audit functions, including fraud and abuse detection and compliance programs.

Notice of Privacy Practices

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Other Uses or Disclosures:

We may also use and disclose your protected health information without your authorization as follows:

Business Associates: An example would be, but not limited to, contracting with a copy service to make copies of your health records. When these services are used, we may disclose your health information to our business associate so they can perform the job we have asked them to do. To make sure your health information is protected, we require our business associates to keep your information confidential.

Notification: We may use or provide 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 judgement, may talk to a family member, other relative, close personal friend or any other person you identify, about health information that is important to the person’s involvement in your care or payment related to your care.

Appointment Reminder: We may contact you as a reminder that you have an appointment for treatment or medical care.

Research: We may provide information to researchers when an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Organ Procurement Organizations: We may provide health information to companies engaged in procuring, banking, or transplanting 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.

Food and Drug Administration (FDA): We may provide to the FDA health information related to adverse events regarding food, supplements, product and produce defects to enable product recalls, repairs or replacement.

Workers Compensation: We may provide health information as authorized by law to worker’s compensation or other similar programs.

Public Health: We may provide your health information to public health or legal representatives responsible for preventing or controlling disease, injury or disability.

**USE AND DISCLOSURE THAT REQUIRES YOUR AUTHORIZATION**

Other than the types of uses and disclosures described above, we will not use or disclose your health information without your written authorization. If you provide us with written authorization, you may take back that authorization at any time unless we have already relied on the authorization or the authorization was required as a condition of insurance coverage by your insurance company. Also, in some situations, federal and state laws may provide special protections for certain kinds of protected health information, such as drug or alcohol treatment records. When required by those laws, we may contact you to receive written authorization to use or disclose that information.

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**Acknowledgement of Receipt of Notice of Privacy Practices**

I have received a copy of the Seattle Nephrology and Endocrinology & Rapha Clinic Notice Of Privacy Practices that describes how my health information is used and shared. I understand Seattle Nephrology and Endocrinology has the right to change this notice at any time.

My signature below affirms my acknowledgement that I have been provided with a copy of the notice of privacy practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_