Executive Medical

1531 Grand Ave. Suite C San Marcos, CA. 92078 - Phone: 760-290-3552 - Email: info@execmed.org

Personal Data

Name	Date	
Address	City State	Zip
Home Phone	Work/Cell Phone	Date of Birth
Employer	Emergency Contact	Phone
Email	Marital Status ☐Married ☐ Single	

Primary Care Physician

Name	Phone/Fax Number	
Address	City State	Zip
Pharmacy Name	Phone/Fax Number	
How did you hear about us?		

Patient History Form

Print Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

Name _____ Date _____ Date of Birth ___/___/___ Age ___

Chief Complaint/History of Present Illness

What is the reason for your visit? (Be as specific as possible)

Past Medical History

Have you ever had any of the following?

- ☐ Anemia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Thyroid problem
- ☐ Cancer
- ☐ Gall Bladder Disease
- ☐ Blood transfusion
- ☐ Pelvic Infection
- ☐ Bladder Infections
- ☐ Genital Herpes
- ☐ Seizures
- ☐ Migraines
- ☐ Liver disease
- ☐ Depression/Anxiety
- ☐ Drug or Alcohol Problem
- ☐ Gonorrhea/Syphilis/Chlamydia
- ☐ Asthma
- ☐ Pneumonia
- ☐ Diabetes
- ☐ Sickle Cell Trait
- ☐ Blood clot in legs/lung
- ☐ Osteopenia

Last colonoscopy _____ Last bone density _____ Last cholesterol check _____

Are you on any medications? Y☐ N☐ (If yes, list all) _____

Do you have any allergies? Y☐ N☐ (If yes, list all) _____

Please list all hospitalizations and surgeries with dates:

Past Obstetrical History

Please list all pregnancies in order (including miscarriages, premature births, abortions, etc...):

Year	Sex	Weight	Type of Delivery	Weeks Pregnant	Anesthetic	Complications

Past Gynecologic History

Date of beginning of last menstrual period _____ Method of birth control _____

Age of first period _____ Are your periods regular? Y☐ N☐

Cycle length _____ Flow: Light☐ Moderate☐ Heavy☐ Pain or cramping? Y☐ N☐

Date of last pap smear _____ Are you sexually active? Y☐ N☐ Past abnormal pap smear? Y☐ N☐

Have you had treatment for an abnormal pap smear? (please list what and when) _____

Date of last mammogram _____ Was it normal? Y☐ N☐

Social History

Do you smoke? Y ☐ N ☐ How much? _____ For how long? _____
Do you drink alcohol? Y ☐ N ☐ How much? _____ For how long? _____
Do you use any street drugs? Y ☐ N ☐ If yes, please list _____

Family History

Has any relative ever had:

	Who		Who		Who
☐ Inherited disease		☐ Heart Trouble		☐ Mental Illness	
☐ Cancer		☐ High Blood Pressure		☐ Stroke	
☐ Diabetes		☐ Kidney Trouble		☐ Tuberculosis	
☐ Epilepsy		☐ Sickle Cell Disease		☐ Bleeding Problems	

Review of Symptoms

Do you currently have any of the following problems? Please check Yes or No

Constitutional Symptoms
Fever/Chills Y ☐ N ☐
Weight loss Y ☐ N ☐
Headache Y ☐ N ☐

Eyes
Blurred Vision Y ☐ N ☐
Double Vision Y ☐ N ☐
Vision Changes Y ☐ N ☐

Allergic/Immunologic
Hay fever Y ☐ N ☐
Medications Y ☐ N ☐

Neurologic
Dizziness Y ☐ N ☐
Seizures Y ☐ N ☐
Numbness/tingling Y ☐ N ☐

Endocrine
Hair loss Y ☐ N ☐
Heat/cold intolerance Y ☐ N ☐

Gastrointestinal
Nausea/vomiting Y ☐ N ☐
Constipation/diarrhea Y ☐ N ☐
Abdominal pain Y ☐ N ☐

Cardiovascular
Chest pain Y ☐ N ☐
Difficulty breathing Y ☐ N ☐
Swelling Y ☐ N ☐
Palpitations Y ☐ N ☐

Respiratory
Wheezing Y ☐ N ☐
Shortness of breath Y ☐ N ☐
Cough Y ☐ N ☐
Sleep apnea Y ☐ N ☐

Musculoskeletal
Joint pain Y ☐ N ☐
Muscle weakness Y ☐ N ☐
Muscle pain Y ☐ N ☐

Ear/Nose/Throat/Mouth
Sore throat Y ☐ N ☐
Sinus problems Y ☐ N ☐
Hearing problems Y ☐ N ☐
Hot flashes Y ☐ N ☐
Excessive thirst Y ☐ N ☐

Hematologic/Lympahatic
Swollen glands Y ☐ N ☐
Frequent bruising Y ☐ N ☐

Psychiatric
Depression/Crying Y ☐ N ☐
Anxiety Y ☐ N ☐
Thoughts of suicide Y ☐ N ☐

Skin
Rash/sores Y ☐ N ☐
Mole changes Y ☐ N ☐

Breast
Nipple discharge Y ☐ N ☐
Lumps Y ☐ N ☐
Skin changes Y ☐ N ☐

Genitourinary
Urine leakage Y ☐ N ☐
Urine retention Y ☐ N ☐
Burning w/urination Y ☐ N ☐
Frequent urination Y ☐ N ☐
Vaginal discharge Y ☐ N ☐
Abnormal bleeding Y ☐ N ☐
Painful periods Y ☐ N ☐
Painful intercourse Y ☐ N ☐
Fibroids Y ☐ N ☐
Infertility Y ☐ N ☐

WEIGHT LOSS QUESTIONNAIRE

Name _____ Date _____

Please complete this questionnaire, which will help you and your physician develop the best management plan for you.

1. Is there a reason you are seeking treatment at this time? _____

2. What are your goals about weight control and management?

_____

3. Your level of interest in losing weight is:
   Not interested 1 2 3 4 5 Very interested

4. Are you ready for lifestyle changes to be a part of your weight control program?
   Not ready 1 2 3 4 5 Very ready

5. How much support can your family provide?
   No support 1 2 3 4 5 Much support

6. How much support can your friends provide?
   No support 1 2 3 4 5 Much support

7. What is the hardest part about managing your weight? _____

_____

8. What do you believe will be of most help to assist you in losing weight?

_____

9. How confident are you that you can lose weight at this time?
   Not confident 1 2 3 4 5 Very confident

Weight History

10. As best as you recall, what was your body weight at each of the following time points (if they apply)?
    Grade school ____ High school____ College____ Age 20-29____ 30-39____ 40-49____ 50-59____

11. What has been your lowest body weight as an adult?____ Your heaviest as an adult?____

12. At what age did you start trying to lose weight?____

13. Please check all previous programs you have tried in order to lose weight. Include dates and length of participation.

Program	Date	Weight (lost or gained)	Length of participation
TOPS	_____	_____	_____
Weight Watchers	_____	_____	_____
Overeaters Anonymous	_____	_____	_____
Liquid diets (Optifast, etc)	_____	_____	_____
Diet pills: Meridia, Xenical	_____	_____	_____
Diet pills: phen-fen, Redux	_____	_____	_____
NutriSystem / Jenny Craig	_____	_____	_____
OTC diet pills	_____	_____	_____
Obesity surgery	_____	_____	_____
Registered dietitian	_____	_____	_____
Other	_____	_____	_____

14. Have you maintained any weight loss for up to 1 year on any of these programs? ____ Yes ____ No

15. What did you learn from these programs regarding your weight?

_____

16. What did not work about these programs? _____

17. Have you been involved in physical activity programs to help with weight loss? ____ Yes ____ No
    Which ones or in what way? _____

Adapted with permission from the Wellness Institute, Northwestern Memorial Hospital.

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Weight Loss Consent

I authorize **Dr. Michael Woo-Ming** to provide medical care to me, including but not limited to the treatment of my weight problem and any coexisting medical conditions. This may involve but not be limited to history taking, in-office testing and physical examination.

I understand that my weight management treatment may consist of specific diet plans, for example a balanced deficit diet, very low calorie diet, a protein supplemented diet; recommendations for behavior modification techniques, including prescribed regular exercise regimens; and possibly the use of over-the-counter and prescription medications, e.g. appetite suppressants. I understand that I may be prescribed medications for medical conditions other than those relating to my weight management according to general medical practice standards.

I understand that if medications are prescribed, especially medications for weight control, their duration of use and prescribed dosage and frequency may exceed or vary with those indicated in the package insert or those set forth by the FDA. It has been explained to me that these medications have been used safely and successfully in private and academic medical practice with appropriate monitoring for periods and at dosing and frequency regimens exceeding or at variance with those recommended in the product literature.

I understand that any medical intervention has associated potential risks and benefits. Risks of this program may include but are not limited to tiredness, weakness, sleep disturbances, headaches, dry mouth, gastrointestinal disturbances, nervousness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. In rare instances these and other possible risks could be serious or even fatal. The benefits of successful weight management may include but not be limited to improved overall health, lower risk of developing serious diseases with at times fatal complications, such as diabetes, breathing problems, joint degeneration, high blood pressure, heart disease, circulation problems, heart attack, stroke, and more. Do not take if you are pregnant, trying to get pregnant or breast-feeding.

I understand that I have alternative treatment options, including but not limited to no treatment at all and weight management programs not supervised by a physician. I also understand that remaining overweight or obese puts me at greater risk for ill health. Some of the complications that may develop as a consequence of prolonged abnormal body weight are arthritis of the joints, especially weight-bearing joints such as hips, knees, feet and back, high cholesterol and triglycerides, high blood pressure, diabetes, vascular disease complicated by stroke, heart attack and abnormal heart rhythms, gallstones, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that the success of weight management treatment depends on my active participation. The staff at Executive Medical cannot guarantee or assure treatment success or any definite outcome. I understand that obesity is considered a chronic condition that may require permanent changes in my eating habits and behavior to attempt success at treatment.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been satisfactorily explained to me. All questions regarding the risks, dangers, and benefits of the proposed treatment have been answered with satisfaction. With my signature I acknowledge that my questions have been answered fully, and that I have been requested to read this form and have been given ample time to understand all its contents.

_____

(Patient Name – Please Print)

_____ _____

(Patient Signature or Signature of Authorized Patient Representative) (Date)

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BHRT Checklist For Men

Name: _____ **Date:** _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

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HIPPA-Health Insurance Portability and Accountability Act

YOUR RIGHTS – Under the federal Health Insurance Portability and Accountability Act (HIPPA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

ACCESS TO YOUR PERSONAL HEALTH INFORMATION – You have the right to inspect and or/obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records.

FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES – With your written consent we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information to the public or private entities to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES: We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For public health activities (reporting of disease, injury, birth, death, or suspicion of child abuse, neglect, or domestic violence)
- To government authority if we believe and individual is a victim of abuse, neglect or domestic violence.
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions)
- For judicial or administrative proceedings (for example pursuant to a court order, subpoena or discovery request)
- For law enforcement purposes (i.e. reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons)
- To advert a serious threat to health or safety under certain circumstances
- For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution.
- For compliance with worker's compensation claims

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Patient:

_____

Signature Date

Witness:

_____

Signature Date

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Patient Consent to Communicate by Email and Telephone

Dear Patient:

Executive Medical has adopted a policy that requires their staff to obtain authorization from the patient to communicate with you by use of email or leaving a detailed message for the patient. This policy is to protect the patient and to also protect the Executive Medical Provider's staff from violating the patient's confidentiality. If the Executive Medical Provider's staff does not have a signed consent on file, the staff may not communicate with you by email. . If the Executive Medical Provider's staff does not have a signed consent on file, the staff may only leave their name and a phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to email or call and leave messages regarding treatment, test results, appointment reminders or other necessary information. Unless notified in writing,

I give consent to my Executive Medical Provider and/or staff of the Executive Medical staff to use my email in the ways described above.

1. _____
   (Email address)
2. _____ On Home Answering Machine (Phone Number)
3. _____ On cell phone voice mail &Text _____ Service provider (Cell Phone Number)
4. _____ On voice mail at work (Work Number)

_____ _____

(Patient Signature) (Date)

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Appointment Cancellation Policy

There will be a $25.00 charge if you fail to cancel your scheduled appointment 24 hours in advance. Your credit card will be billed $25.00 on the day of your visit if you fail to cancel your appointment 24 hours prior to the scheduled time. This will not be the case when rescheduling for the same week.

Print Name: _____

Signature: _____

Date: _____