Rocklin Family Practice & Sports Medicine

Roy Harris, M.D. • Kuo Ooi, M.D. • Biljinder Chima, M.D. • Sharndeep Bains, D.O.

Patient Name: _____ **Sex:** ☐M ☐F **Date of Birth:** _____
First Middle Last

Social Security: _____ **Email Address:** _____

Race:_____ **Ethnicity:** ☐Hispanic ☐Non-Hispanic ☐Decline to State **Preferred Language:**_____

Mailing Address: _____ **City** _____ **State** _____ **Zip** _____

Home Address: _____ **City** _____ **State** _____ **Zip** _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ **Occupation:** _____

Employer Address: _____ **City** _____ **State** _____ **Zip** _____

Spouse's Name:_____ Social Security: _____ DOB: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Immediate family members living with you: _____

EMERGENCY CONTACT

Nearest relative not living with you:_____ Relation: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( )_____

RESPONSIBLE PARTY – If patient is a minor please name parent or guardian

Name: _____Social Security: _____ DOB: _____
(Use name of legally responsible person)

Mailing Address: _____ City _____ Zip _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( )_____

MEDICAL INSURANCE

WE BILL INSURANCE COMPANIES WITH WHICH ROY M. HARRIS M.D., INC. IS CONTRACTED, OTHER WISE PAYMENT IS DUE AT THE TIMEOF SERVICE.

Insurance Company: _____ Subscriber's Name:_____

I.D. # : _____ Group #: _____ Subscriber's DOB:_____

PATIENT OR AUTHORIZED PERSON SIGNATURE - Read and initial each statement

____ I authorize all medical treatment as deemed necessary by Roy M. Harris M.D., Inc. and affiliated providers.
____ I authorize release of any medical or other information necessary to process claims.
____ I authorize my insurance carrier to make payment directly to Roy M. Harris M.D., Inc. for any medical services rendered.
____ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.
____ I understand I may be charged **$25.00** if I do not show for an appointment or give less than a 24-hour notice to cancel or reschedule.
____ I have received and read the "Advance Directives" and "HIPPA" Notice of Privacy Practices.
____ I give permission for the staff to leave a message when calling to confirm appointments.

Signature X _____ **Date:** _____

Rev. 7/11

Patient Questionnaire

NAME:_____ **SEX** ☐ Male ☐ Female **AGE:** _____ **TODAY'S DATE**_____

MARITAL STATUS
- ☐ Married
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Never married

YOUR BACKGROUND
- ☐ Black (not Hispanic)
- ☐ Hispanic
- ☐ White (not Hispanic)
- ☐ Asian
- ☐ Other- describe: _____

HOW FAR YOU WENT IN SCHOOL
- ☐ 8th grade or less
- ☐ Some high school
- ☐ High school graduate or equivalency (GED)
- ☐ Some college or associate degree
- ☐ Completed college

INSTRUCTIONS: This questionnaire will help your doctor better understand problems that you may have. Your doctor may ask you more questions about some of these items. Please make sure to check a box for <u>every</u> item that applies.

During the **PAST MONTH**, have you **OFTEN** been bothered by…						During the **PAST MONTH…**		
	YES	**NO**		**YES**	**NO**		**YES**	**NO**
1. stomach pain	☐	☐	12. Have you had any: • constipation	☐	☐	22. have you had an anxiety attack (suddenly feeling fear or panic)	☐	☐
2. back pain	☐	☐	• diarrhea	☐	☐			
3. pain in your • arms • legs • joints • knees • hips • other	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	13. Have you had any: • nausea • gas • indigestion	☐ ☐ ☐	☐ ☐ ☐	23. have you thought you should cut down on your drinking of alcohol	☐	☐
4. menstrual pain or problems	☐	☐	14. feeling tired or having low energy	☐	☐	24. has anyone complained about your drinking	☐	☐
5.pain or problems during sexual intercourse	☐	☐	15.trouble sleeping	☐	☐	25. have you felt guilty or upset about your drinking	☐	☐
6. headaches	☐	☐	16. the thought that you have a serious undiagnosed disease	☐	☐	26. was there ever a single day in which you had five or more drinks of beer, wine, or liquor	☐	☐
7. chest pain	☐	☐	17. your eating being out of control	☐	☐	**Overall would you say your health is:**		
8. dizziness	☐	☐	18. little interest or pleasure in doing things	☐	☐	Excellent Very good Good Fair Poor	☐ ☐ ☐ ☐ ☐	
9. fainting spells	☐	☐	19. feeling down, depressed or hopeless	☐	☐			
10. feeling your heart pound or race	☐	☐	20. "nerves" or feeling anxious or on edge	☐	☐			
11. shortness of breath	☐	☐	21. worrying about a lot of different things	☐	☐			

Fill out this page if you are 65 or older

Name:_____
Date:_____

Rocklin Family Practice & Sports Medicine

Roy Harris, MD | Kuo Ooi, MD | Biljinder Chima, MD | Sharndeep Bains, DO
3104 Sunset Blvd Ste. 2B Rocklin, CA 95677 | Phone: (916) 624-0300 | Fax: (916) 624-0631

Annual Well Visit & Physical Questionnaire

PATIENT PORTION

List your current providers & suppliers that provide regular medical care (including specialists, suppliers of oxygen, TENS units, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you have the following in your household (please circle):

1. Rugs: YES / NO
2. Handrails: YES / NO
3. Grab bars in bathroom: YES / NO
4. Poor lighting: YES / NO

Do you feel that you are at risk for falls? YES / NO
Do you feel that you have a hearing impairment? YES / NO

1. In the last 2 weeks, have you had little interest or pleasure in doing things nearly every day? YES / NO
2. In the last 2 weeks have you had thoughts that you would be better off dead or of hurting yourself in some way? YES / NO

THIS SECTION FOR OFFICE STAFF ONLY

Vaccines	**Screenings**
Flu Shot	Colorectal >50 years – Q10yrs PRN
Tdap – every 10 years	Prostate 50-75 years PRN
Pneu >65 years – at least once	MAMM >40
Shingles >60 years – once	DEXA >65
Learn: B: Y/N F: Y/N T: Y/N	**Recall:** B: Y/N F: Y/N T: Y/N
Clock - draw small & large hand 10 min to one:	

Take this test if you are a man age 40 or older

You may feel embarrassed to talk to your doctor about urinary problems. But, like gray and thinning hair, such problems are part of again for many men. A benign, treatable condition called benign prostatic hyperplasia (BPH) causes urinary symptoms for a quarter of men over the age of 50 and 40% of men over the age of 60.

Take this quiz to help you and your doctor decide whether you need treatment for BPH.

Taking the Quiz Please circle the answer that best represents your response to each of the following questions. The questions are designed to gauge the severity of any symptoms you may be experiencing.	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Patient Score
1 Incomplete emptying Over the past month how often have you had a sensation of not emptying your bladder completely after you have finished urinating?	0	1	2	3	4	5	
2 Frequency Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	0	1	2	3	4	5	
3 Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4 Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5 Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6 Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7 Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5+	

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible	
Quality of life due to urinary symptoms If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6	

Adapted from Barry MJ et al: The American Urological Association symptoms index for benign prostatic hyperplasia. J Urol 1992;148(5):1549-57

Scoring the Quiz

Add the numbers from your answers to questions 1-7. The maximum possible score is 35. The final question will help you judge how you *feel* about your symptoms.

Please note: This test is used to measure the severity of your symptoms. It is not a diagnostic test. In other words, it will not tell you whether or not you have BPH. Talk with your doctor to determine whether your symptoms are due to BPH.