

HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____

PAST MEDICAL HISTORY

Anemia.....	NO	YES	Hepatitis.....	NO	YES	Polio.....	NO	YES
Asthma.....	NO	YES	Kidney Disease.....	NO	YES	Rheumatic Fever...	NO	YES
Cancer.....	NO	YES	Liver Disease.....	NO	YES	Scarlet Fever.....	NO	YES
Chicken Pox	NO	YES	Measles.....	NO	YES	Seizure.....	NO	YES
Diabetes.....	NO	YES	Mumps.....	NO	YES	Stroke.....	NO	YES
Gout.....	NO	YES	Peptic Ulcer.....	NO	YES	Thyroid Disease...	NO	YES
Heart Disease.....	NO	YES	Phlebitis/Blood Clot...	NO	YES	Tuberculosis.....	NO	YES
Hypertension.....	NO	YES	Pneumonia.....	NO	YES	Venereal Disease..	NO	YES

PAST SURGICAL HISTORY:

Any other significant illnesses, injuries or hospitalizations:

Year _____	Illness _____	Year _____	Surgery _____
Year _____	Illness _____	Year _____	Surgery _____
Year _____	Illness _____	Year _____	Surgery _____
Year _____	Illness _____	Year _____	Surgery _____

ALLERGIES: (Medications and Foods)

LIST OF CURRENT MEDICATIONS

1. _____	Reaction _____	1. _____	5. _____
2. _____	Reaction _____	2. _____	6. _____
3. _____	Reaction _____	3. _____	7. _____
4. _____	Reaction _____	4. _____	8. _____

IMMUNIZATIONS:

SOCIAL HISTORY:

Year _____	Marital Status: S M Sep D W	# Children _____
Influenza	Occupation: _____	Hrs / Wk: _____
Tetanus	Job Satisfaction: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumococcol	Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pack / Day: # _____
Others:	Caffeine: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cups / Drinks / Day: # _____
	Alcohol: (Kinds, Amounts, Frequency)	
	Recreational Drugs:	
	Advanced Directive / Living Will: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Family History	Age	If Living: Health	If Deceased: Age (at death) & Cause	Has any blood relative ever had:	
Father				Cancer	No Yes
Mother				Tuberculosis	No Yes
Sibling				Diabetes	No Yes
				Heart Trouble	No Yes
Spouse				High Blood Pressure	No Yes
Children				Stroke	No Yes
				Convulsions	No Yes
				Suicide	No Yes
				Mental Illness	No Yes
				Bleeding Tendencies	No Yes
				Arthritis or Gout	No Yes
				Hereditary Defects	No Yes

SYSTEM REVIEW

GENITOURINARY

Do you eat a well balanced diet? ----- NO YES
 Approx Weight: Now _____ 1 year ago: _____
 Maximum weight: _____
 Exercise? Frequency / wk: _____ NO YES
 Activities: _____
 Any Sexual Concerns? _____ NO YES
 Year of Last Complete Physical: _____
 Headaches ----- NO YES
 Glasses / Contacts ----- NO YES
 Double Vision ----- NO YES
 Eye Disease or Injury ----- NO YES
 Year Last Checked For Glaucoma: _____
 Itchy Eyes or Nose / Hay Fever ----- NO YES
 Septal Deviation / Polyps (Circle Which) --- NO YES
 Nosebleeds ----- NO YES
 Sinus Problems ----- NO YES
 Ear Disease ----- NO YES
 Impaired Hearing ----- NO YES
 Ringing in the Ears (Tinnitus) ----- NO YES
 Hoarseness ----- NO YES

NECK

Softness ----- NO YES
 Enlarged Glands ----- NO YES
 Injury ----- NO YES

RESPIRATORY

Coughing Blood ----- NO YES
 Chronic Cough (Includes Smoker's Cough) --- NO YES
 Wheezing ----- NO YES
 Shortness of Breath ----- NO YES
 How many blocks can you walk without
 having to stop and catch your breath? _____
 Night Sweats ----- NO YES
 Skin Test for Tuberculosis ----- NO YES
 If YES, Year of Test and Results: _____
 Year of Last X-Ray: _____

CARDIOVASCULAR

Chest Pain or Angina Pectoris ----- NO YES
 Shortness of Breath (when lying flat) ----- NO YES
 Pain in legs on walking, relieved by rest ----- NO YES
 Varicose Veins ----- NO YES
 Ankles often badly swollen ----- NO YES
 Heart Murmur ----- NO YES
 Rapid, hard or skipped heart beats ----- NO YES
 Year of Last EKG? _____
 Have had a stress treadmill? Year _____ NO YES

GASTROINTESTINAL

Change in Appetite ----- NO YES
 Heartburn or Indigestion ----- NO YES
 Sour Taste in your throat or mouth ----- NO YES
 Intolerance to spicy foods, coffee or alcohol - NO YES
 Have you ever vomited blood? ----- NO YES
 Do foods stick in your throat? ----- NO YES
 Gallbladder trouble / intol. to greasy foods --- NO YES
 Intolerance to milk products ----- NO YES
 Hiatal Hernia ----- NO YES
 Pancreatitis ----- NO YES
 Do you vomit often? ----- NO YES
 Crampy Abdominal Pain ----- NO YES
 Chronic Constipation ----- NO YES
 Frequent Diarrhea ----- NO YES
 Change in Bowel Habits ----- NO YES
 Bloody or Black Bowel Movements ----- NO YES
 Hemorrhoids or Piles ----- NO YES

GENITOURINARY

Loss of Urine when coughing or sneezing? ----- NO YES
 Kidney or Bladder Infections (Circle which) ----- NO YES
 Burning or Frequent Urination (Circle which) ----- NO YES
 Feeling that you must go immediately? ----- NO YES
 Do you get up at night to urinate? # _____ NO YES
 Blood in Urine ----- NO YES
 Kidney Stones ----- NO YES
 Swelling of the hands and feet ----- NO YES
 Difficulty starting Urination ----- NO YES
 Decrease in Strength of Stream ----- NO YES
 Penile Discharge ----- NO YES
 Date of last Prostate Exam: _____

MUSCULOSKELETAL

Significant Arthritis / Joint Pain ----- NO YES
 Lower Back Pain ----- NO YES
 Muscle Weakness or Tenderness ----- NO YES
 Difficulty Walking ----- NO YES
 Fractures (list) ----- NO YES

SKIN

Skin Disorders (list) ----- NO YES

NEUROLOGICAL / PSYCHIATRIC

Numbness / Paralysis (Circle which) ----- NO YES
 Fainting Spells ----- NO YES
 Memory Loss ----- NO YES
 Dizziness ----- NO YES
 Do you have trouble sleeping? ----- NO YES
 Are you often depressed? ----- NO YES
 Are you often anxious or nervous? ----- NO YES
 Do you ever wish you were dead and away from it all? ----- NO YES
 Do you often worry? ----- NO YES
 Have you ever been under psychiatric care? ----- NO YES

HEMATOLOGICAL

Excessive Bleeding or Abnormal Bruising ----- NO YES

ENDOCRINE

Crave large amounts of fluids ----- NO YES
 Intolerance to slightly warm rooms ----- NO YES
 Intolerance to slightly cool rooms ----- NO YES
 Change in textures of hair or skin ----- NO YES
 Darkening of Skin ----- NO YES

GYNECOLOGICAL (This Section For Women Only)

Age when period began: _____ years old
 Frequency: every _____ days, Last Period: _____
 Are they abnormal or irregular? ----- NO YES
 Menopausal? If so at what age? ----- NO YES
 Number of Pregnancies: _____ C-Sections: _____
 Term Deliveries: _____ Premature: _____
 Miscarriages: _____ Abortions: _____
 Pelvic Inflammatory Disease ----- NO YES
 Pain with Intercourse ----- NO YES
 Date of Last Cancer Smear: _____ Normal? ----- NO YES
 Breast Masses, Lumps or Cysts (Circle which) ----- NO YES
 Nipple Discharge ----- NO YES
 Skin Discoloration / Dimpling (Circle which) ----- NO YES
 Family History or Breast Cancer ----- NO YES
 Date of Last Mammogram: _____
 Did someone other than the patient help fill this out? ----- NO YES

Patient Signature: _____

Reviewing Physician: _____

Dr. Neysan Bayat
26671 Aliso Creek Road, Suite 205
Aliso Viejo, CA. 92656
Ph (949) 832-0300
Fax (949) 831-0339

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS
FROM MEDICAL PROVIDERS

I hereby authorize **NEYSAN BAYAT, M.D.** to obtain any and all medical records concerning my care from any physician, hospital or other health care professionals that have provided care to me at any time. Additionally, I authorize Dr. Mehrnaz Nicole Jamali to release any and all medical records concerning my care to Medicare, Medicaid and any insurance company, third party.

Patient Signature

Date

Print Name

Date of Birth

Please fax records to our office at (949) 831-0339

HEALTHCARE ELIGIBILITY WAIVER

Patient Name

Health Plan

Neysan Bayat, M.D.

The Patient or Patient's Legal Representative hereby certifies that he / she is eligible for health benefits coverage, and has chosen the above stated physician as the provider of his / her healthcare.

Furthermore, the Patient or Patient's Legal Representative understands that if he/ she is found ineligible for coverage of plan benefits, he / she is financially responsible for all costs incurred during the delivery of health services, and agrees to pay these charges to the physician accordingly.

Patient Signature

Date

Witness

Date

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Doctor's Office
26671 Aliso Creek Road, Suite 205
Aliso Viejo, CA. 92656

To All of Our Patients:

Due to the high volume of patients in our practice, we ask that you give us 24-hour notice if your appointment needs to be changed or canceled. This policy enables us to accommodate as many patients as possible, in a timely manner, and will help our office to handle your needs more efficiently.

You will be billed \$50.00 for any appointments that you miss without giving prior notice and a fee of \$25.00 will be charged for any appointment that was cancelled within 24 hours prior to your appointment.

Thank you,

Printed Name

Signature

Date

Neysan Bayat, M.D.

Dear Patients of Neysan Bayat, M.D.

Please be advised that with the insurance information provided in the office we will bill as accordingly. Once insurance pays you are then responsible for any balance left on your account. If payment is not received within 10 days of your statement there will be a 30% late fee charge added to your balance.

Financial Agreement: I accept financial responsibility for all services during any episodes of care done in the office. I understand that I can expect to receive separate bills from **physicians, labs, and specialty services.** I agree to promptly pay all bills, in accordance with the regular rates and terms of the office. Should the account be referred to an attorney or agency for collections, I will pay actual attorney's fees and collection expenses. All delinquent accounts are subject to interest at the legal rate.

Assignment of Insurance Benefits: I assign and authorize direct payment to the office of all insurance and plan benefits that are payable for this episode of care. With this authorization, all parties agree that the insurance company's obligations related to this episode of care. I further understand that I am financially responsible for charges not paid according to this assignment.

Medicare Assignment: I certify that the information given by me in applying for payment from any third party payer including payment under Title XVII of the Social Security Act is correct. I request that payment of authorization benefits be made on my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Medicare Part B, including but not limited to the effective date of such coverage. I also authorize the office and my physician(s) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claim(s).

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of financial Agreement and Assignment of Insurance Benefits.

Patient Name _____ Patient Signature _____

Witness _____ Date _____