Terry C. Lin D.O., Inc.

PATIENTS PERSONAL INFORMATION

Marital Status: □ Single □ Married □ Divorced □ Widowed Sex: □Male □Female

Name: _____ _____ _____
Last Name First Name Middle Initial

Street Address: _____ D.O.B: ____/____/____
Month Day Year

City: _____ State: _____ Zip: _____

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

Email:____ _____ □ Opt out of Patient Portal Social Security #:_____ - _____ - _____

Race: □ American Indian or Alaska Native □ Asian □ African American □ Native Hawaiian or Other Pacific Islander
□ White □ Decline to Answer

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Answer Language Preference: _____

Employer: _____ □ Part Time □ Full Time

Address: _____ City:_____ State: _____ Zip:_____

Occupation: _____

Spouse Name: _____ Spouse Social Security#: _____ - _____ - _____
Last First Initial

Spouse's Employer: _____ Spouse Work Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please give receptionist insurance card

Primary Insurance Company: _____

Name of Insured: _____ D.O.B:____/____/____ Relationship to Insured:_____

Insurance ID #: _____ Group #: _____

Secondary Insurance Company:_____

Name of Insured: _____ D.O.B: ____/____/____ Relationship to Insured: _____

Insurance ID#: _____ Group #: _____

REFERRAL INFORMATION

Referred by: _____Phone#: (_____) _____

Primary Care Physician: _____ Phone #: (_____) _____

Other Physician: _____ Phone #: (_____) _____

COMMUNICATIONS

Preferred method of receiving confidential info: □Email □Mail □Home Ph □Cell Ph □Patient Portal

Emergency Contact: _____ Phone # : (_____) _____

For all office appointments we require a 24 hour notice and for all procedures we require a 72 hour notice of cancellations. If the cancellation policy is not kept or you are considered to be a "NO SHOW" the day of the procedure or office appointment, a broken appointment fee may incur.

Signature: _____ **Date:** _____

I directly assign all medical/surgical benefits to the doctor and understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize Dr. Terry Lin to release all information necessary to secure payment of benefits. I understand the doctor's office may be unable to determine if a valid authorization for services is required or has been obtained, or if the physician is currently a participating provider. I further agree that a photocopy of this original shall be as valid as the original

Signature_____ **Date:** _____

Clinical Health Questionnaire

Please complete this form as accurately as possible:

Name: _____

DOB: _____ Age: _____ Gender: M F

Physicians currently treating you:

_____

_____

Reason for visit: _____

Have you had a flu shot: □ Yes □ No Date of shot: _____

Past Medical History (current or past illnesses)

Heart

High Blood Pressure	☐Yes	☐No
High Cholesterol	☐Yes	☐No
Coronary Artery Disease	☐Yes	☐No
Irregular Heart Beat	☐Yes	☐No
Heart attack	☐Yes	☐No

Other: _____

Lung

COPD	☐Yes	☐No
Emphysema/Chronic Bronchitis	☐Yes	☐No
Asthma	☐Yes	☐No
Pneumonia	☐Yes	☐No

Other: _____

Gastrointestinal

Reflux Disease (Hiatal Hernia)	☐Yes	☐No
Peptic Ulcer Disease	☐Yes	☐No
Gall Bladder Disease	☐Yes	☐No
Hepatitis B or C	☐Yes	☐No
Inflammatory Bowel disease (Crohn's, Ulcerative Colitis)	☐Yes	☐No
Liver Cirrhosis	☐Yes	☐No

Other: _____

Endocrine

Diabetes	☐Yes	☐No
Thyroid Disease	☐Yes	☐No

Other: _____

Cancer

Ever diagnosed with cancer?	☐Yes	☐No

Year diagnosed _____

Type of Cancer: _____

Are you on Treatment?	☐Yes	☐No

Blood Disorders

Anemia	☐Yes	☐No
Bleeding disorders	☐Yes	☐No

Other: _____

Musculoskeletal System

Osteoarthritis	☐Yes	☐No
Gout	☐Yes	☐No
Autoimmune Disease	☐Yes	☐No

If yes, please explain: _____

_____

Other: _____

Peripheral Vascular Disease

Deep Vein Thrombosis (DVT)	☐Yes	☐No
Pulmonary Embolism (PE)	☐Yes	☐No
Varicose Veins	☐Yes	☐No
Arterial Vascular Disease	☐Yes	☐No

Other: _____

Psychological Disorders

Depression	☐Yes	☐No
Anxiety	☐Yes	☐No

Other: _____

Neurologic Disorders

Stroke	☐Yes	☐No
Alzheimer's	☐Yes	☐No

Other: _____

Pregnancy status: □ Yes □ No If yes how many months_____

Other illnesses not listed above: 1. _____

2._____ 3._____

Past Surgical History (please list all prior surgical procedures)

☐None

Type of surgery: _____ Year: _____

Type of surgery: _____ Year: _____

Type of surgery: _____ Year: _____

Type of surgery: _____ Year: _____

Have you had any complications after surgery? ☐Yes ☐No

If yes, please explain:_____

_____

Family History (Circle M-Mother F-Father S-Sister B-Brother)

Gallstones	M	F	S	B
Colon Polyps	M	F	S	B
Diabetes	M	F	S	B
High Blood Pressure	M	F	S	B
Hemochromatosis (Iron storage disease)	M	F	S	B
Ulcers	M	F	S	B
Colon Cancer	M	F	S	B
Depression	M	F	S	B
Arthritis	M	F	S	B
Hepatitis	M	F	S	B
Liver Cancer	M	F	S	B
Heart Disease	M	F	S	B
Colitis	M	F	S	B
Crohn's disease	M	F	S	B

Other Liver Diseases: _____

Other Cancers: _____

Genetic Diseases: _____

Has any family member had any of the following?

Difficulty with Anesthesia:	☐Yes	☐No
Excessive bleeding after a procedure:	☐Yes	☐No

If yes, please explain: _____

Social History

Tobacco use: ☐Current ☐Past ☐None

If yes, average use: ___pack/day Duration: ___years

Quit (if applicable) ___Years ago

Alcohol Use: ☐Current ☐Past ☐None

If yes, average use: __drinks/week

When was your last drink: _____

Quit (if applicable) __years ago

Recreational Drug Use: □ Yes □ Never □ Quit

Review of Systems

Please circle any of the following symptoms you might have Experienced over the past 3 months (if this form is left blank we will assume that there have been no issues)

Constitutional: Fever, Chills, Tiredness, Weight loss >10lbs

Psychologic: Anxiety, Depression, Difficulty Sleeping

Neurologic: Dizziness, Hand/Feet tingling or numbness

Eyes: Blurry Vision, Eye Pain

Ear/Nose/Throat: Ear ache, Nose Bleed, Change in Voice

Heart: Chest pain, Shortness of Breath, Heart Palpitations

Lungs: Cough, Sputum, Shortness of Breath, Wheezing

Gastrointestinal: Abdominal pain, Heartburn, Nausea, Vomiting, Bloating, Diarrhea, Constipation, Blood from Rectum

Genitourinary: Burning with Urination, Increased frequency, Difficulty Controlling Bladder, Penile or Vaginal Discharge

Musculoskeletal: Pain in joints, muscles, or bones

Skin: Skin rash, Excessive itching, Eczema, Dry skin

Hematologic: Excessive bruising, swollen glands

Allergies:

Please list all allergies and reactions.

Drug Allergy	Reaction

Current Medications

Please list all prescribed and over-the-counter medications,
Including nutritional and herbal supplements you are currently taking.
(Please submit separate list if your list is longer then what this table allows)

Prescription Medication	Dose (mg, iu, cc)	Frequency

Name, phone#, address of your pharmacy: _____