~ WELCOME ~

Date :______________

Patient Information

First Name:____________________________ Last Name:____________________________ Initial:_____

Male: ____ Female: ____ Married: ____ Single: ____ Divorced: ____ Widowed: ____ Partnered: ____

SSN:______________Birthdate:___________Race:____________Preferred Language:________________

P.O.Box:________________City:____Zip:______________

Physical Address:____

City: ____Zip: ____________________

Home:____ Cell Phone:______________________________

Email :____

Retired:________________ Student:_________________ Home Maker:__________________

Employer:____ Occupation:_____________________

Emergency Contact:____ Phone:___________________

Primary Insurance

Insurance Company:____

Insurance ID # :____

Main Subscriber Name:____ Birthdate:_________________

Secondary Insurance

Insurance Company: ____

Insurance ID #: ____

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand I am responsible for any co-payment, deductible and non covered benefits. I authorize the use of this signature on all insurance submissions.

Signature of patient/representative:_______________________________________ Date:______________

KYI KYI THWIN WIN, M.D.
INTERNAL MEDICINE

P.O. BOX 2229
29099 HOSPITAL RD., #107
LAKE ARROWHEAD, CA 92352

Patient Name: ______________________

Date: __________ **DOB:** __________ **Gender: M / F**

****Please answer every question on both sides of this form****

Please check conditions, which you have had in the past:

CVS
- ○ Rheumatic Fever
- ○ High Cholesterol
- ○ Congestive Heart Failure
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Angina
- ○ Frequent Chest Pain
- ○ Irregular Heartbeat
- ○ Heart Murmur
- ○ Heart Valve Disease
- ○ Blood Clots in Veins
- ○ Blocked Arteries in Neck
- ○ Blocked Arteries in Legs

Lymphatic / Hematologic
- ○ Diabetes Mellitus
- ○ Overactive Thyroid
- ○ Underactive Thyroid
- ○ Anemia
- ○ Thyroid Goiter
- ○ Blood Transfusion

Skin / Breast
- ○ Acne
- ○ Eczema / Psoriasis
- ○ Fibrocystic Breast Disease
- ○ Abnormal Mammogram
- ○ Rashes
- ○ Hives
- ○ Moles

Respiratory
- ○ Sleep Apnea
- ○ Frequent Bronchitis
- ○ Emphysema
- ○ Pneumonia
- ○ Asthma
- ○ Clots in Lungs
- ○ Tuberculosis

Musculoskeletal / Extremities
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis
- ○ Joint Pain
- ○ Gout
- ○ Broken Bones
- ○ Osteoporosis
- ○ Osteopenia
- ○ Fibromyalgia
- ○ Neck Pain (hern. disc)
- ○ Back Pain (herniated disc)

HEENT
- ○ Glasses / Contacts
- ○ Glaucoma
- ○ Cataracts
- ○ Hearing Loss
- ○ Frequent Ear Infections
- ○ Ringing in Ears
- ○ Allergies
- ○ Frequent Sinus Infections
- ○ Mouth Sores

Neurologic / Psychiatric
- ○ Seizure
- ○ TIA
- ○ Stroke
- ○ Numbness
- ○ Weakness
- ○ Memory Loss
- ○ Migraine Headaches
- ○ Depression
- ○ Anxiety
- ○ Panic Attacks
- ○ Suicide Attempt
- ○ Physical Abuse
- ○ Sexual Abuse
- ○ Mental Illness
- ○ Dizziness
- ○ Vertigo
- ○ Peripheral Nerve Disease
- ○ Insomnia

General
- ○ Abnormal Weight Loss
- ○ Abnormal Weight Gain
- ○ Cancer/Tumor _______

____

_______ # of Pregnancies

_______ Live Births

_______ Miscarriages

_______ Abortions

GI /GU
- ○ Heartburn
- ○ Stomach Ulcers
- ○ Gallstones
- ○ Blood in Stool
- ○ Hepatitis
- ○ Diarrhea / Constipation
- ○ Hemorrhoids
- ○ Abdominal Pain
- ○ Colon Polyps
- ○ Urinary Frequency
- ○ Bladder Infections
- ○ Prostate Disease
- ○ Urinary Incontinence
- ○ Kidney Stones
- ○ Kidney Failure
- ○ Ulcerative Colitis
- ○ Crohn's Disease
- ○ Diverticulitis/Diverticulosis
- ○ Irritable Bowel Disease
- ○ Cirrhosis of the Liver
- ○ Liver Failure
- ○ Pancreatitis
- ○ Endometriosis
- ○ Abnormal PAP
- ○ Sex Transmitted Infection
- ○ HIV Infection

Provider Notes: ______________________

____

Please list any allergies or intolerance to drugs or other substances: ______________________

____

____

Please list the medications currently taken, their dosages, and how many times per day you take them:

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Please indicate any surgeries you have had and the year you had them:

- ○ Angioplasty ________
- ○ Carotid Artery ________
- ○ Other Vascular ________
- ○ Coronary Bypass ________
- ○ Chest/Lung ________
- ○ Tonsillectomy ________
- ○ Neurosurgery ________
- ○ Trauma Related ________
- ○ Back/neck ________
- ○ Hip ________
- ○ Knee ________
- ○ Carpal Tunnel ________
- ○ Sinus ________
- ○ Ear ________
- ○ Stomach ________
- ○ Inguinal Hernia ________
- ○ Colonoscopy ________
- ○ Gallbladder ________
- ○ Appendectomy ________
- ○ Prostate ________
- ○ Bladder ________
- ○ Tubal Ligation ________
- ○ C-Section ________
- ○ Hysterectomy ________
- ○ Ovary Removed ________
- ○ Breast ________
- ○ Thyroid ________
- ○ Other ________

Provider Notes: ________

Please indicate when you last had any of the following preventative tests or services:

- ○ Cardiac Angiogram ________
- ○ Stress Test ________
- ○ EKG ________
- ○ Chest X-Ray ________
- ○ Echocardiogram ________
- ○ Flu Vaccine ________
- ○ Pneumonia Vaccine ________
- ○ Tetanus Vaccine ________
- ○ Hepatitis Vaccine ________
- ○ Bone Density Test ________
- ○ PSA Blood Test ________
- ○ Rectal Exam ________
- ○ Colon Cancer Stool Test ________
- ○ Flexible Sigmoidoscopy ________
- ○ Barium Enema ________
- ○ Colonoscopy ________
- ○ Mammo/Breast Exam ________
- ○ PAP Smear ________
- ○ Last Menstrual Period ________
- ○ Other ________

Provider Notes: ________

Family Medical History

Please check major illness in your family members (mother, father, brother, sister, or children)

- ○ Tuberculosis
- ○ Emphysema
- ○ Heart Disease
- ○ High Blood Pressure
- ○ Osteoporosis
- ○ Diabetes Mellitus
- ○ Thyroid Disease
- ○ Anemia
- ○ Hemophilia
- ○ High Cholesterol
- ○ Kidney Disease
- ○ Epilepsy
- ○ Neurologic Disorder
- ○ Liver Disease
- ○ Hepatitis
- ○ Breast Cancer
- ○ Ovarian Cancer
- ○ Colon Cancer
- ○ Prostate Cancer
- ○ Skin Cancer

Provider Notes: ________

Do you have a :
Durable Power of Attorney? ☐ Yes ☐ No **If yes, list person(s)** ________
Healthcare representative? ☐ Yes ☐ No **If yes, list person(s)** ________
Living Will? ☐ Yes ☐ No **Out of hospital Do Not Resuscitate (DNR)** ☐ Yes ☐ No
Did you bring copies of above documents with you today? ☐ Yes ☐ No **Would you like information on any of the above?** ☐ Yes ☐ No

FAMILY HISTORY Follow lines across the page. Mark appropriate box.	Alive & well	Deceased	Age at Death	Cause of Death	High blood pressure	Heart disease	High cholesterol	Diabetes	Cancer	Asthma/lung disease	Tuberculosis	Arthritis	Kidney disease	Glaucoma	Stroke	Migraine	Mental illness	Alcoholism	Bleeds easily	Anemia	Gout	Seizures	Other
FATHER																							
☐ GF ☐ GM																							
MOTHER																							
☐ GF ☐ GM																							
☐ BRO ☐ SIS																							
☐ BRO ☐ SIS																							
☐ BRO ☐ SIS																							
☐ BRO ☐ SIS																							

Personal Information

Marital Status: ○ **Single** ○ **Married** ○ **Separated** ○ **Divorced** ○ **Widowed**

What is or was your occupation? ________

Who is currently living in your home? ________

Do you use tobacco products? ________ **If so, how much:** ________

Do you or have you used recreational drugs (marijuana, heroin, cocaine, LSD, etc.)? ________

How much alcohol do you consume weekly? ○ **None** ○ **0 – 5** ○ **6 – 12** ○ **>12**

What are your current dietary patterns? ________

Exercise on regular basis? ________

Notice Of Privacy Practices:

Acknowledgment of Receipt

By signing this form, you acknowledge of the *Notice of Practices of* {Kyi Kyi Thwin Win, M.D., Inc.}

Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: (*contacting our office at 909-337-0059)*

If you have any questions about our *Notice of Privacy Practices,* please contact privacy officer :

James Win

I acknowledge receipt of the *Notice of Privacy Practices of* {Kyi Kyi Thwin Win , M.D., Inc.}
29099 Hospital Rd. Ste 107
Lake Arrowhead, Ca 92352

Signature: ______________________________ Date: ______________

[patient/parent/conservator/guardian]

Inability to obtain acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained: ______________________

____

____

Signature of provider representative: ______________________ Date: __________

Kyi Kyi Thwin Win , M.D., Inc.
29099 Hospital Rd. Ste.107
Lake Arrowhead, Ca 92352

Health Insurance Portability and Accountability patient consent

We may call your designated phone number to inform you of your test results. If we can not reach you in person, we will request that you call us back to discuss the results. In either case, you will have to identify yourself with a pass word. Please write your password here {________________}. Please record your password in a safe place and do not share the password.

We may disclose your health information to a family member, close personal friend or any person you identify. Below, please list the names and relationships of the persons you would allow us to disclose your medical information:

name	relationships
______________________	______________
______________________	______________
______________________	______________
______________________	______________

It is our practice to call patients the day before the appointment as a reminder.

Dr.Win's office may call my telephone number and leave a reminder message regarding pending appointments.

☐ yes ☐ no

______________________ signature ______________ date

______________________ ______________