

# MISSION VALLEY MEDICAL CLINIC

5333 Mission Center Road, Suite 100 • San Diego, CA 92108 • (619) 295-3355

www.missionvalleymedical.com

## PATIENT REGISTRATION (PLEASE PRINT)

Patient's Name		_____			_____		_____		_____	
		Last	First		Middle		Social Security Number			
Date of Birth		_____	_____	_____	Sex: M F					
		Mo	Day	Yr	Age					
Home Address:		_____			_____		_____		_____	
		Street		Apt #	City		State		Zip	
Home Phone:		_____			Cell Phone:		_____			
Email:		_____								
Employer:		_____			Work Phone:		_____			
Occupation:		_____								
Work Address:		_____			_____		_____		_____	
		Street		Apt. #	City		State		Zip	
Driver's License No:		_____								
Allergies to Medications:		_____								
Conditions Seeking Treatment For:		_____								
How Did You Hear Of Our Facility?		_____								

Emergency Contact:		_____		Relation:		_____		Telephone Number:		_____	
Address:		_____									
Nearest Relative Not Living With You:		_____						Relation:		_____	
Address:		_____						Telephone Number:		_____	

Primary's Name:		_____			Date of Birth:		_____		_____		_____	
		Mo	Day	Yr	Social Security Number							
Address		_____			_____		_____		_____		_____	
		Street		City		State		Zip				
Sex: M F		_____										
Phone:		_____										
Spouse's Name :		_____						Phone:		_____		

### AUTHORIZATION:

I understand that I am financially responsible for all charges, whether or not covered by my insurance company. I hereby consent to medical treatment/physical examination; I also consent that you may contact me via email regarding outstanding balances and/or address corrections.

Office use only

### ASSIGNMENT:

I permit payment directly to Drs. Office any benefits due for their services rendered.

Initial

### MEDICAL RECORDS:

Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim for negotiating a settlement on a disputed claim.

### WORKERS' COMPENSATION CLAIMS

I Hereby certify that the information I have provided, regarding my industrial injury, is true and correct. (ANYONE WHO KNOWINGLY MAKES A FALSE OR FRAUDULENT STATEMENT TO OBTAIN OR DENY SOMEONE WORKERSCOMPENSATION BENEFITS COULD BE GUILTY OF A FELONY):

Signature : \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**MISSION VALLEY MEDICAL CLINIC  
MEDICAL HISTORY QUESTIONNAIRE**

Name \_\_\_\_\_

Last

First

Middle

Job Title

Birthdate

Age

<b>PAST SURGERIES</b>	<b>Yes</b>	<b>No</b>	<b>Date</b>	<b>(If "yes" give date)</b>	<b>Yes</b>	<b>No</b>	<b>Date</b>
Appendectomy:				Hysterectomy. Complete:			
Abdominal surgery:				Hernia surgery:			
Bladder surgery:				Gallbladder surgery:			
Bowel surgery:				Tonsilectomy & Adenoidecomy:			
Cataract surgery:				Orthopedic surgery:			
Hemorrhoidectomy:				Other surgery:			
Hysterectomy. Partial:				No past surgery:			

<b>PAST HISTORY</b>	<b>Yes</b>	<b>No</b>	<b>(If "yes" please explain)</b>
Cancer			
Stroke			
Diphtheria or smallpox			
Malaria Scarlet or Typhoid Fever			
Poliomyelitis			
Rheumatic Fever			
Philepitis or varicos veins			
Serious anemia			
Blood disease			
Bleeding tendency			
Hay fever or asthma			
Treatment with cortisone			
Medicine to thin blood			
Hormone treatments			
Allergies: (meds., pollen, etc.)			Please list

<b>SKIN</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Skin rashes			Moles or warts removed that bleed		
Skin cancer			If "Yes" please explain:		

<b>NEUROMUSCULAR</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Headaches			Dizzy spells or "blackouts"		
Convulsions			Numbness		
Paralysis			Serious head injury		
Tremors			Speech difficulty		
Memory loss			Mental illness		
Head injuries			If "Yes" please explain:		

<b>BONES &amp; JOINTS</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Arthritis or Rheumatism			Back injuries		
Knee or ankle injuries			Broken bones		
Other serious injuries			List & give dates:		

<b>ENDOCRINE</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Diabetes			Thyroid trouble		
Other gland problems			If "Yes" please explain below:		

<b>EYES</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Failing vision			Spells of blindness		
Double vision			Spots in vision		
Cataracts			Glaucoma		
Eye pain			Glasses or contact lenses		
If "Yes" please explain:			How long:	All the time	Reading only

EARS	Yes	No		Yes	No
Hearing loss			Ear drainage		
Ringing in ears			Ear pain		
Ear infection			If "Yes" please explain:		
<b>NOSE</b>					
	Yes	No		Yes	No
Nasal discharge			Loss of sense of smell		
Trouble breathing through bottom of nose			Sinus trouble		
Nose bleeds			If "Yes" please explain:		
<b>MOUTH</b>					
	Yes	No		Yes	No
Wear dentures			How long? Full Set? Partial?		
Teeth need dental care			Difficulty swallowing		
Sores or growths in mouth			Prolonged hoarseness		
Chronic sore throat			If "Yes" please explain:		
<b>HEART &amp; LUNGS</b>					
	Yes	No		Yes	No
Ever take heart medication			Irregular or fast heart beat		
Emphysema			Pneumonia or bronchitis		
Tuberculosis			Chronic cough		
Coughing of blood			Heart attack		
Wake up short of breath			Shortness of breath with activity		
High blood pressure			Sleep with more than one pillow		
Chest pain			Ever had EKG		
Ever had chest X-Ray			Date of most recent:		
Date of most recent:					
If "Yes" please explain:					
<b>GASTRO INTESTINAL</b>					
	Yes	No		Yes	No
Abdominal pain			Persistent nausea		
Ulcers			Gallstones or gallbladder trouble		
Take laxatives			Jaundice		
Liver trouble			Intolerance to certain foods		
Vomiting of blood			Blood in stools		
Black colored stools			Diarrhea		
Constipation			Change in bowel habits in past year		
Hemorrhoids			If "Yes" please explain:		

Have you ever taken insulin or other medication for Diabetes? \_\_\_Yes \_\_\_No

Have you been treated for Alcoholism? \_\_\_Yes \_\_\_No

How much alcohol do you consume per week? Beer \_\_\_\_\_ Wine \_\_\_\_\_ Hard liquor \_\_\_\_\_

How much do you smoke per day? None \_\_\_\_\_ Cigarettes \_\_\_\_\_ Pipe \_\_\_\_\_ Cigar \_\_\_\_\_ How many years \_\_\_\_\_

Have you ever had an injury or illness on the job? \_\_\_Yes \_\_\_No

A. How many job related illnesses or injuries have you had in the past year? Indicate what types: \_\_\_\_\_

Have you ever lost time from work due to illness or injury? \_\_\_Yes \_\_\_No

A. How much time have you lost in the past year? \_\_\_\_\_

Were you ever hospitalized because of a work injury or illness? \_\_\_Yes \_\_\_No

A. How many times have you been hospitalized in the past year? \_\_\_\_\_

Have you ever had an auto accident? \_\_\_Yes \_\_\_No

If yes. When? Before work? \_\_\_\_\_ After work? \_\_\_\_\_ Weekends or Vacation? \_\_\_\_\_

List any illnesses caused by previous jobs: \_\_\_\_\_

*I certify that the information given by me is true and complete to the best of my knowledge and belief. I consent to its use in any proceeding wherein it may be relevant and material. I understand that falsification of medical information is cause for disqualification or dismissal.*

Date

Social Security No.

Signature