Coast Pulmonary & Internal Medicine Associates
ABHISHEK BHARDWAJ,MD & Vinev Soni, M.D.
9940 TALBERT AVE. #101 FOUNTAIN VALLEY, CA 92708
Tel (714) 545-8700 Fax (714) 545-8084

Date_____ Home Phone_____

May we leave detailed messages? Yes____ No____ Cellular Phone_____

PATIENT NAME:_____ Date of Birth_____/_____/_____

Mailing Address:_____
Street address City State Zip

Male_____ Female_____ Single____Married____Separated____Divorced____Widow_____

Social Security #_____-_____-_____ Email Address_____

Employer_____Occupation_____

Business Phone #_____Ext._____. Ok to call? Yes_____ No_____

Name of Spouse_____Contact Phone #_____

Spouses Employer_____SS#(If primary insured)_____-_____-_____

INSURANCE: PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S)

1) Primary Insurance_____Group#_____

Primary Insured Name_____Relationship_____

2) Secondary Insurance_____Group#_____

Person to notify in case of an emergency? (Not living with you)

Name_____Relationship_____Phone_____

WHO REFERRED YOU TO OUR OFFICE?_____

What is your PRIMARY LANGUAGE SPOKEN?_____

Do you need an interpreter? Yes_____ No_____

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to pay the proceed of any benefits due, directly to Coast Pulmonary. I authorize the release of medical information to my insurance for payment purposes and referring physician.

SIGNED_____Date_____

Your Name _____ DOB _____

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SYSTEMIC REVIEW:

General: Recent weight change .....NO YES
Vomiting blood or food.....NO YES
Skin: Jaundice.....NO YES
Neck: Thyroid Trouble.....NO YES
Respiratory: Spitting up Blood..... NO YES
Frequent Cough..... .NO YES
Asthma or wheezing.....NO YES
Difficulty Breathing..... NO YES
Cardiovasular: Chest Pain.....NO YES
Heart Trouble or heart attack.....NO YES
Swelling of hands or feet.....NO YES
Heart Murmur..... NO YES
Urinary: Frequent Urination..... NO YES
Nighttime Urination..... NO YES
Blood in Urine..... NO YES
Ears,Nose & Throat: Double Vision..NO YES
Nosebleeds.....NO YES
Eye Disease or Injury.....NO YES
Hearing Impaired ..... NO YES
Glaucoma..... NO YES
Chronic Sinus trouble.....NO YES
Dizziness or episodes
Unconsciousness.....NO YES
Headaches.....NO YES
Mental Health: Have you had :
Stress.....NO YES
Depression..... NO YES
Anxiety/Panic Attacks..... ....NO YES
Family or Marriage Problems.....NO YES

Gastrointestinal (Stomach):
Peptic Ulcer..... NO YES
Vomiting Blood or Food.....NO YES
Gallbladder Disease..... NO YES
Liver toruble.....NO YES
Hepatitis..... .NO YES
Painful bowel movements.....NO YES
Bleeding or Black stools.....NO YES
Hemorrhoids or piles.....NO YES
Change in bowel habits..... NO YES
Frequent Diarrhea..... ... NO YES
Heartburn or Indigestion..... .NO YES
Kidney Trouble..... NO YES
Musculoskeletal: Pain in Joints or Restrictive Movement
Shoulder.....NO YES
Elbow.....NO YES
Wrist..... ...NO YES
Hand.....NO YES
Neck..... ...NO YES
Back .....NO YES
Hip..... NO YES
Knee..... NO YES
Ankle..... .NO YES
Foot..... ..NO YES

FEMALES ONLY:
Gynecological:
Age menstrual periods started _____
How long to periods last? _____
Frequency of periods - every _____ Days
Number of Pregnancies _____
Number of Children _____
Date of Last Period _____

Coast Pulmonary & Internal Medicine Associates

Your Name: _____ Your Age: _____ DOB _____

HISTORY OF PAST ILLNESS : Have you had ?

Childhood:
Measles..... .....NO YES
Mumps..... NO YES
Diabetes..... NO YES
Chickenpox..... NO YES
Heart Disease..... NO YES
High Blood Pressure..NO YES
Ulcer Disease.....NO YES
Other:_____...NO YES

Adult:
Have you had any serious injuries? _____
_____
Have you been hospitalized?..... NO YES
If yes, for what reason? _____
_____

Operations:
Have you ever had surgery? ..... NO YES List: _____
Injuries:
Have you ever had broken bones..... NO YES List: _____
Serious Injuries ? ..... NO YES List: _____
Immunizations :
Did you receive childhood vaccinations ?..... NO YES When was your last TETNUS injection? _____
Family History:
Has any blood relative had?
Cancer ..... NO YES
Tuberculosis..... NO YES
Diabetes ..... NO YES
High Blood Pressure.....NO YES
Heart Trouble.....NO YES
Convulsions.....NO YES
Social History:
Alcoholic Beverages:
Type of Drink _____ How many? _____ Per Day?____ Per Wk?____ Per Mo?____
History of Substance Abuse..... NO YES Year _____
Tobacco: Cigarettes _____ Packs per day_____ Years_____ Other:_____
Sexual Orientation: Hetrosexual _____ Homosexual_____Bisexual_____
Blood Transfusions.....NO YES

ALLERGIES: Please list ADVERSE REACTION
Medication:_____
Environmental:_____
Foods:_____

CURRENT MEDICATIONS:

Name of Medication:	Strength:	How Often:	What are you taking it for?

Reviewed By:

Coast Pulmonary & Internal Medicine Associates
John H. Eilbert M.D. & Viney Soni, M.D.
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Tel (714) 545-8700 Fax (714 545-8084

Personal Information
Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F): _____Today's Date (MM/DD/YY) :_____Provider:_____

CALIFORNIA TUBERCULOSIS RISK ASSESSMENT

Tools to identify asymptomatic adults for latent TB infection (LTBI) testing. Recommended if any of the 3 boxes are checked.

- ☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month
  - Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
  - If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see California Adult Tuberculosis Risk Assessment User Guide of this list)
  - Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for foreign-born persons ≥ 2 years old
- ☐ **Immunosuppression**, current or planned
  - HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥ 15 mg/day for ≥1 month) or other immunosuppressive medication
- ☐ **Close contact** to someone with infections TB disease during lifetime

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- ☐ **None;** no TB testing is indicated at this time

HEREDITARY CANCER QUESTIONNAIRE

***Please notify the medical staff if you qualify for a cancer risk assessment.**
***Do not eat or drink anything 30 minutes prior to test. *Most insurance plans cover this test. You will be notified if any payment required.**

PLEASE CHECK ALL THAT APPLY

Breast and Ovarian Cancer Risk

- ☐ Personal history of breast cancer diagnosis less than 50 years old
- ☐ Family history of more than 3 breast cancers on the same side of the family
- ☐ Personal and/or family history of ovarian, male breast, metastatic prostate, or pancreatic cancer
- ☐ Ashkenazi Jewish ancestry and history of breast cancer

Prostate Cancer Risk

- ☐ Personal and/or family history of metastatic prostate cancer
- ☐ Personal and or family history of high grade (≥ 7 Gleason score) prostate cancer AND any of the following:
  - 1 or more relative with breast cancer diagnosed at or before 50 years old
  - 2 or more relatives with breast or prostate cancer at any age
- ☐ Family history of ovarian cancer OR pancreatic cancer OR male breast cancer

Colorectal Cancer Risk

- ☐ Personal history of colorectal cancer diagnosed before 50 years old
- ☐ Family history of 3 or more colorectal cancers on the same side of the family
- ☐ Personal and/or family history of pancreatic cancer
- ☐ Personal history of 10 of more colon polyps (adenomas) in your lifetime