Chang Lee M.D.
399 E Highland Ave #223
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Tel: 909-475-5200

GYNECOLOGY INFORMATION SHEET

Please complete these forms and return it to the receptionist. Thank you. (Por Favor llene y firme estas formas. Regrese estas formas a la recepcionista cuando termine. Gracias)

DATE (FECHA) _____/_____/_____ GENDER -- MALE / FEMALE

1. PATIENT INFORMATION

LAST NAME (APELLIDO): _____FIRST NAME (NOMBRE):_____
PRIMARY LANGUAGE _____ DO YOU NEED A TRANSLATER? YES OR NO

ADDRESS (DOMICILIO): _____
CITY/STATE/ZIP (CUIDAD, ESTADO, CODIGO POSTAL) _____
_____**TELEPHONE** (TELEFONO) (_____)_____
CELL PHONE NUMBER (_____)_____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #_____-_____-_____
(FECHA DE NACIMIENTO) (# DE SEGURO SOCIAL)

SINGLE (SOLTERA)_____ MARRIED (CASADA)_____ DIVORCED (DIVORCIADA)_____
WIDOWED (VIUDA)_____ SEPARATED (SEPERADA)_____ MINOR (MENOR DE EDAD)_____

EMPLOYER (EMPLEADOR) _____
EMPLOYER PHONE NUMBER (NUMERO DE TELEFONO DE EMPLEADOR): (_____)_____
OCCUPATION (OCUPASION)_____

EMERGENCY CONTACT - IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? (EN CASO DE UNA EMERGENCIA, A QUIEN DEBEMOS LLAMAR?)
NAME (NOMBRE) _____
RELATIONSHIP TO PATIENT (RELACION CON EL PACIENTE):_____
HOME TELEPHONE NUMBER (NUMERO DE CASA): (_____)_____
WORK TELEPHONE NUMBER (NUMERO DE EL TRABAJO: (_____)_____

2. RESPONSIBLE PARTY (PERSONA RESPONSIBLE):
NAME (NOMBRE) _____D.O.B (FECHA DE NACIMIENTO____/_____/____
RELATIONSHIP TO PATIENT (RELACION CON EL PACIENTE)_____
OCCUPATION (OCUPASION) _____
SS# (SEGURO SOCIAL) _____/_____/_____

3. INSURANCE INFORMATION (INFORMACION DE SU ASEGURANZA)
NAME OF INSURED (NOMBRE DE QUIEN LE PERTENECE LA ASEGURANZA)
_____
NAME OF INSURANCE: _____ POLICY #_____ GROUP #_____
(NOMBRE DE ASEGURANZA) # DE POLISA

4. AUTHORIZATION AND RELEASE (AUTORIZACION):
I HEREBY CONSENT TO AND AUTHORIZE THE ADMINISTRATION OF ALL DIAGNOSTIC AND THERAPEUTIC TREATMENTS THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGMENT OF THE ATTENDING PHYSICIAN. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT.
I (PATIENT OF GUARDIAN) AM AN ELIGIBLE MEMBER OF THIS DATE OF SERVICE OF A HEALTH PLAN AND A COPY OF THE BENEFITS CARD IS ATTACHED TO THIS DOCUMENT. SIGNATURE OF THE RESPONSIBLE PARTY BELOW ACKNOWLEDGES FULL FINANCIAL

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RESPONSIBILITY OR SERVICES RENDERED TO ME IF IT IS DETERMINED I AM NOT ELIGIBLE ON THE DATE OF SERVICE IN QUESTION OR IF SERVICES RENDERED IS DETERMINED TO BE NON-COVERED BENEFIT UNDER THE PLAN PROVISIONS.
I HEREBY IRREVOCABLE AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED CORPORATION/PHYSICIAN, BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE CORPORATION'S/ PHYSICIAN'S REGULAR CHARGE DUE AS A RESULT OF THIS CLAIM. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE CORPORATION/PHYSICIAN FOR CHARGES NOT COVERED.

PATIENT/GUARDIAN SIGNATURE (FIRMA DE EL PACIENTE O PADRES SI ES MENOR DE EDAD) _____ DATE (FECHA)_____

5. SURGERY OUTCOME

WE WISH YOU GOOD LUCK AND BEST OUTCOME POSSIBLE. HOWEVER, WE CANNOT GUARANTEE A GOOD OUTCOME. RISKS OF HAVING SURGICAL PROCEDURE INCLUDE BLEEDING, INFECTION, DAMAGE TO ORGANS, AND DEATH. ALTHOUGH WE TRY HARD TO PREVENT COMPLICATIONS, WE CANNOT GUARANTEE THAT YOU WILL NOT HAVE ANY PROBLEMS DURING OR AFTER THE PROCEDURE.

SIGNATURE_____ DATE_____

6. MENTRUAL HISTORY

At what age did you start having periods?
_____
When was the first day of your last period?
_____
How often do you have your period?
Every 25 days _____
Every 30 days _____
Every 35 days _____
Every Month _____
Every few month_____
How many days is your normal flow? _____
How many pads or tampons do you use a day while on your period? _____

PLEASE CHECK THE ANY THAT APPLIES TO YOU:

Period every few months _____
Irregular Periods _____
Having more than 8 days of flow _____
Using more than 8 pads or tampons per day while on the period _____
Pain with your period _____
Pain with superficial penetration _____
Pain with deep penetration _____
Hot flashes _____
Night sweats _____

7. SEXUAL HISTORY

How many sexual partners do you have in the last year? _____
Do you engage in oral sex? _____ Anal Sex _____
Do you have sex with men? ____ Women? ____
How many times did you have sexual intercourse in the last week? _____

PLEASE CHECK ANY THAT APPLIES TO YOU

Chlamydia _____
Gonorrhea _____
Herpes _____
Trichomonas _____
Syphilis _____
Pelvic Inflammatory Disease _____
HPV _____

8. CONTINENCE HISTORY

PLEASE CHECK ANY THAT APPLIES TO YOU:

Lose urine unintentionally _____
Lose urine with coughing, sneezing, laughing or lifting _____
Lose stool unintentionally _____
Drink two or more cups of tea or coffee _____
Waking up at night two or more times to urinate _____
Have a strong urge to urinate _____
Have frequent urination _____
Have pain with urination _____

CHANG L. LEE, M.D.
OBSTETRICS AND GYNECOLOGY

Medical Questionnaire

Name: _____

Date of Birth: _____

What is your main concern today?_____
_____
_____

Please circle if you have any of the following medical conditions:

Diabetes mellitus	High blood pressure	Heart disease
Headaches	Seizures	Lung disease
Stroke	Neuropathy	Low back pain
Neck pain	High cholesterol	

Other Medical Problems:_____
_____
_____

Please List Any Surgeries:_____
_____
_____

Please List Any Medications You Take (If you already have a written list of medications, please give it to the medical assistant to photocopy):_____
_____
_____
_____

Do you smoke?	Yes	No	How much?
Do you drink alcohol?	Yes	No	How much?
Do you use any street drugs?	Yes	No	Which ones?

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