



**Patient Name:** \_\_\_\_\_ **Sex:**  M  F **Date of Birth:** \_\_\_\_\_  
First Middle Last

**Social Security:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Race:** \_\_\_\_\_ **Ethnicity:**  Hispanic  Non-Hispanic  Decline to State **Preferred Language:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Spouse's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Immediate family members living with you: \_\_\_\_\_

**EMERGENCY CONTACT**

**Nearest relative:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**RESPONSIBLE PARTY – If patient is a minor please name parent or guardian**

**Name:** \_\_\_\_\_ **Social Security:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
(Use name of legally responsible person)

**Mailing Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**MEDICAL INSURANCE**

**WE BILL INSURANCE COMPANIES WITH WHICH ROCKLIN FAMILY PRACTICE AND SPORTS MEDICINE IS CONTRACTED, OTHERWISE PAYMENT IS DUE AT THE TIME OF SERVICE.**

**Insurance Company:** \_\_\_\_\_ **Subscriber's Name:** \_\_\_\_\_

**I.D. # :** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **Subscriber's DOB:** \_\_\_\_\_

**PATIENT OR AUTHORIZED PERSON SIGNATURE – Read and initial each statement**

I authorize all medical treatment as deemed necessary by Rocklin Family Practice and Sports Medicine and affiliated providers.  
I authorize release of any medical or other information necessary to process claims.  
I authorize my insurance carrier to make payment directly to Rocklin Family Practice and Sports Medicine for any medical services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.  
I understand I may be charged **\$25.00** if I do not show for an appointment or give less than a 24-hour notice to cancel or reschedule.  
I have received and read the "Advance Directives" and "HIPPA" Notice of Privacy Practices.  
I give permission for the staff to leave a message when calling to confirm appointments.  
The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

**Signature X** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Patient Questionnaire

NAME: \_\_\_\_\_ SEX  Male  Female AGE: \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**MARITAL STATUS**

- Married
- Widowed
- Separated
- Divorced
- Never married

**YOUR BACKGROUND**

- Black (not Hispanic)
- Hispanic
- White (not Hispanic)
- Asian
- Other- describe: \_\_\_\_\_

**HOW FAR YOU WENT IN SCHOOL**

- 8th grade or less
- Some high school
- High school graduate or equivalency (GED)
- Some college or associate degree
- Completed college

**INSTRUCTIONS:** This questionnaire will help your doctor better understand problems that you may have. Your doctor may ask you more questions about some of these items. Please make sure to check a box for every item that applies.

During the PAST MONTH, have you OFTEN been bothered by...			During the PAST MONTH...					
	YES	NO		YES	NO		YES	NO
1. stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any:	<input type="checkbox"/>	<input type="checkbox"/>	22. have you had an anxiety attack (suddenly feeling fear or panic)	<input type="checkbox"/>	<input type="checkbox"/>
2. back pain	<input type="checkbox"/>	<input type="checkbox"/>	• constipation	<input type="checkbox"/>	<input type="checkbox"/>			
			• diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
3. pain in your	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any:	<input type="checkbox"/>	<input type="checkbox"/>	23. have you thought you should cut down on your drinking of alcohol	<input type="checkbox"/>	<input type="checkbox"/>
• arms	<input type="checkbox"/>	<input type="checkbox"/>	• nausea	<input type="checkbox"/>	<input type="checkbox"/>			
• legs	<input type="checkbox"/>	<input type="checkbox"/>	• gas	<input type="checkbox"/>	<input type="checkbox"/>			
• joints	<input type="checkbox"/>	<input type="checkbox"/>	• indigestion	<input type="checkbox"/>	<input type="checkbox"/>			
• knees	<input type="checkbox"/>	<input type="checkbox"/>	14. feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	24. has anyone complained about your drinking	<input type="checkbox"/>	<input type="checkbox"/>
• hips	<input type="checkbox"/>	<input type="checkbox"/>						
• other	<input type="checkbox"/>	<input type="checkbox"/>						
4. menstrual pain or problems	<input type="checkbox"/>	<input type="checkbox"/>	15. trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	25. have you felt guilty or upset about your drinking	<input type="checkbox"/>	<input type="checkbox"/>
5. pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	16. the thought that you have a serious undiagnosed disease	<input type="checkbox"/>	<input type="checkbox"/>	26. was there ever a single day in which you had five or more drinks of beer, wine, or liquor	<input type="checkbox"/>	<input type="checkbox"/>
6. headaches	<input type="checkbox"/>	<input type="checkbox"/>	17. your eating being out of control	<input type="checkbox"/>	<input type="checkbox"/>			
7. chest pain	<input type="checkbox"/>	<input type="checkbox"/>	18. little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<b>Overall would you say your health is:</b>		
8. dizziness	<input type="checkbox"/>	<input type="checkbox"/>	19. feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	
9. fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	20. "nerves" or feeling anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	Very good	<input type="checkbox"/>	
10. feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	21. worrying about a lot of different things	<input type="checkbox"/>	<input type="checkbox"/>	Good	<input type="checkbox"/>	
11. shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>				Fair	<input type="checkbox"/>	
						Poor	<input type="checkbox"/>	

Fill out this page if you are 65 or older

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Annual Well Visit & Physical Questionnaire

### PATIENT PORTION

List your current providers & suppliers that provide regular medical care (including specialists, suppliers of oxygen, TENS units, etc.):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Do you have the following in your household (please circle):

1. Rugs: YES / NO
2. Handrails: YES / NO
3. Grab bars in bathroom: YES / NO
4. Poor lighting: YES / NO

Do you feel that you are at risk for falls? YES / NO

Do you feel that you have a hearing impairment? YES / NO

1. In the last 2 weeks, have you had little interest or pleasure in doing things nearly every day? YES / NO
2. In the last 2 weeks have you had thoughts that you would be better off dead or of hurting yourself in some way? YES / NO

### THIS SECTION FOR OFFICE STAFF ONLY

Vaccines	Screenings
Flu Shot	Colorectal >50 years – Q10yrs PRN
Tdap – every 10 years	Prostate 50-75 years PRN
Pneu >65 years – at least once	MAMM >40
Shingles >60 years – once	DEXA >65
<b>Learn:</b> B: Y/N F: Y/N T: Y/N	<b>Recall:</b> B: Y/N F: Y/N T: Y/N
<b>Clock</b> - draw small & large hand 10 min to one:	

## Take this test if you are a man age 40 or older

You may feel embarrassed to talk to your doctor about urinary problems. But, like gray and thinning hair, such problems are part of again for many men. A benign, treatable condition called benign prostatic hyperplasia (BPH) causes urinary symptoms for a quarter of men over the age of 50 and 40% of men over the age of 60.

Take this quiz to help you and your doctor decide whether you need treatment for BPH.

Taking the Quiz Please circle the answer that best represents your response to each of the following questions. The questions are designed to gauge the severity of any symptoms you may be experiencing.	Patient Score						
	Not at all	Less than 1 time in 5	About half the time	More than half the time	Almost always		
<b>1 Incomplete emptying</b> Over the past month how often have you had a sensation of not emptying your bladder completely after you have finished urinating?	0	1	2	3	4	5	
<b>2 Frequency</b> Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	0	1	2	3	4	5	
<b>3 Intermittency</b> Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
<b>4 Urgency</b> Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
<b>5 Weak stream</b> Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
<b>6 Straining</b> Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
<b>7 Nocturia</b> Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5+	
Quality of life due to urinary symptoms If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	Patient Score						
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly dissatisfied	Unhappy	
	0	1	2	3	4	5	6

Adapted from Barry MJ et al: The American Urological Association symptoms index for benign prostatic hyperplasia. J Urol 1992;148(5):1549-57

### Scoring the Quiz

Add the numbers from your answers to questions 1-7. The maximum possible score is 35. The final question will help you judge how you *feel* about your symptoms.

**Please note:** This test is used to measure the severity of your symptoms. It is not a diagnostic test. In other words, it will not tell you whether or not you have BPH. Talk with your doctor to determine whether your symptoms are due to BPH.