Vernon A. Rosario, MD, PhD

A Medical Corporation

10850 Wilshire Blvd., Suite 1210
Los Angeles, CA 90024
310-470-9775

ADULT MEDICAL SCREENING

Patient Information

NAME:	DATE OF BIRTH: _____/_____/_____
SOCIAL SECURITY #:	
Address:	
Home phone:	Work phone:
Fax:	Mobile phone:
Occupation:	Email:
Marital Status:	Educational level:

Chief Complaint

(SPECIFY ONSET AND DURATION):

Personal Medical History

Do you receive regular medical care from a physician or clinic? ☐ NO ☐ YES

If yes, please provide the following information:

Name of physician or clinic:

Address:

CURRENT MEDICATIONS:

MEDICATION ALLERGIES: Penicillin ☐ NO ☐ YES. Other:

Have you ever had any of the following:

Condition			Condition		
Birth Defects	☐ NO	☐ YES	Colitis	☐ NO	☐ YES
Broken Bones	☐ NO	☐ YES	Rheumatic Fever	☐ NO	☐ YES
Drug Poisoning	☐ NO	☐ YES	Tuberculosis	☐ NO	☐ YES
Injuries	☐ NO	☐ YES	Gonorrhea	☐ NO	☐ YES
Severe Cuts or Lacerations	☐ NO	☐ YES	Syphilis	☐ NO	☐ YES
Asthma	☐ NO	☐ YES	Meningitis or Encephalitis	☐ NO	☐ YES
High Blood Pressure	☐ NO	☐ YES	Epilepsy	☐ NO	☐ YES
Diabetes	☐ NO	☐ YES	Headaches	☐ NO	☐ YES
Cancer	☐ NO	☐ YES	Stroke	☐ NO	☐ YES
Thyroid Disease	☐ NO	☐ YES	Head Injury	☐ NO	☐ YES
Other Hormone Problem	☐ NO	☐ YES	Concussion	☐ NO	☐ YES
Alcoholism	☐ NO	☐ YES			
Peptic (Stomach) Ulcers	☐ NO	☐ YES			

If yes, please explain (continue on the back):

Have you had any other disease? ☐ NO ☐ YES If yes, explain:

What is your current weight (estimate if you do not know exactly)?

What is the most you have ever weighed? lbs. When?

Can you explain any recent weight loss or weight gain?

Have you ever had to be hospitalized? ☐ NO ☐ YES If yes, complete the following:

Year	Doctor's Name	Name of Hospital

Have you ever had surgery , or been advised to have surgery? ☐ NO ☐ YES If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Name of Operation or Procedure

Do you have Hay Fever or food allergies?

Have you recently had any of the following tests?		When and why?
Physical Exam	☐ NO ☐ YES:	
Blood Tests	☐ NO ☐ YES:	
Chest X-ray	☐ NO ☐ YES:	
Electrocardiogram (E KG)	☐ NO ☐ YES:	
Brain Scan (MRI, CT)	☐ NO ☐ YES:	
EEG	☐ NO ☐ YES:	

Have you ever used the following and how much do you currently consume?

Coffee (cups/day)	☐ NO ☐ YES:	Aspirin	☐ NO ☐ YES:
Cigarettes (packs/day)	☐ NO ☐ YES:	Laxatives	☐ NO ☐ YES:
Marijuana (joints/day)	☐ NO ☐ YES:	Alcohol (amount and types used daily)	☐ NO ☐ YES:
Vitamins	☐ NO ☐ YES:		

Sleeping Pills ☐ NO ☐ YES:

Have you ever used any of the following? (Circle the ones used)

Celexa	Prozac	Luvox	Paxil	Zoloft
Wellbutrin	Remeron	Serzone	Effexor	Lexapro
Buspar	Cymbalta	Tegretol	L-Dopa	Cogentin
Lithium	Depakote	Topamax	Neurontin	Lamictal
Valium	Librium	Dilantin	Dalmane	Klonopin
Ativan	Restoril	Xanax	Serax	Halcion
Anafranil	Sinequan	Tofranil	Elavil	Pamelor
Haldol	Prolixin	Trilafon	Navane	Stelazine
Orap	Loxitane	Moban		
Thorazine	Mellaril	Serentil		
Zyprexa	Risperdal	Seroquel	Geodon	Clozaril
Abilify	Phenobarbital	Other barbiturates:		
Amphetamines	Ritalin	Dexedrine	Other stimulants:	
Heroin	Codeine	Methadone	Percodan	Dilaudid
Talwin	Darvon	Demerol		
Quaaludes	Ambien	Sonata	Other sedatives:	
Cocaine	Glue/inhalants			

Please detail periods of use, dosages, reasons for use, and reason for discontinuation of the above (continue on reverse).

Personal Psychiatric History

Have you ever received any previous psychiatric or psychological evaluation or treatment? ☐ NO ☐ YES If yes, complete the following (continue on back):

Year	Doctor	Clinic or Hospital	Reason	Medication Used (if any)

Have you ever attempted suicide? ☐ NO ☐ YES If yes, please describe when, how, what happened?

Family History

Please describe any family history of medical illnesses (such as cancer, hypertension, diabetes, neurological disorders):

Please describe any family history of mental health problems, such as depression, manic-depression (bipolar), anxiety, schizophrenia, suicides, substance use, learning disorders, autism:

Review of Your Current Health

Do you have any of the following? (Please circle)

Unusual excessive thirst	Skin problem
Weight loss or weight gain	Urine problems, blood in urine
Weakness or tiredness	Joint pain
Thyroid problem, goiter	Lumps anywhere
Shortness of breath at night or with exercise	Double vision or poor vision
Cough or wheeze	Difficulty hearing
Chest pain	Fainting spells / blackout spells
Palpitation or heart fluttering	Convulsion
Swelling of hands or feet	Trouble sleeping
Indigestion, gas, heartburn	Sexual problems
Spitting up blood	Depression
Vomiting / vomiting blood	Problems with memory, thinking, or concentration
Stomach pain or stomach ulcer	Suicidal thoughts
Diarrhea	Auditory hallucinations
Constipation	Visual hallucinations
Blood in stool	
Change in appetite or eating habits	

Please describe on the reverse any of the positive answers above.

FOR WOMEN ONLY:

Date your last menstrual period began: Number of pregnancies:

Number of children born alive: Number of therapeutic abortions: .

Number of miscarriages or stillbirths: Have you had a Pap smear within the last year? ☐ NO ☐ YES

Do you use any contraceptive method? ☐ NO ☐ YES If yes, which?

Do you examine your breasts for lumps? ☐ NO ☐ YES

PATIENT'S SIGNATURE: DATE: _____/_____/_____

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

Vernon A. Rosario II, MD, PhD
10850 Wilshire Blvd. Suite 1210
Los Angeles, CA 90024 310-470-9775

I hereby acknowledge that I reviewed and downloaded a copy of this medical practice's *Notice of Privacy Practices* on-line at:

http://vrosario.bol.ucla.edu/forms/HIPAA_PatientNotice.pdf

I further acknowledge that a copy of the most current notice will be available on-line
A print copy of the current Notice of Privacy Practices will be available at each appointment upon request.

Signed: ______________________________Date: __________________________________
Print Name: __________________________Telephone: _____________________________

If not signed by the patient, please indicate relationship:

- ❏ Parent or guardian of minor patient
- ❏ Guardian or conservator of an incompetent patient

Name and Address of Patient: ____
____
____