LOS GATOS MEDICAL GROUP
Family Medicine & Urgent care

M.SHAMALA, MD
FAMILY MEDICINE

555 Knowles Drive, Ste # 200
Los Gatos, CA 95032
Tel: 408.370 0200
Fax: 408.370 0202

NEW PATIENT QUESTIONNAIRE

** Some of this information is required by the CMS (Centers for Medicare and Medicaid Services). Your demographic answers will never affect your care.*

Today's Date:_____ Date of Birth:_____

First Name Middle Initial Last Name

☐ Male ☐ Female

Primary Language: ☐ English ☐ Spanish ☐ Chinese
☐ Other _____

Race: ☐ White ☐ Black/African-American ☐ Asian
☐ American Indian/Eskimo ☐ Pacific Islander
☐ Other _____

Ethnicity: ☐ non-Hispanic ☐ Hispanic

Social Security Number (if Medicare): ☐☐☐-☐☐-☐☐☐☐

_____
Street Address

_____
City State Zip Code

Cell Phone #: _____ Home Phone #: _____

Email Address (prefer your "forever" address):

_____

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Occupation: _____
Employer/School: _____
Work Phone #: _____

If you are disabled: ☐ Temporary ☐ Permanent

Emergency Contact Name: _____
Relation to you: _____
Emergency Contact Phone #: _____

Do you allow the doctor to disclose health information in case of emergency to your Emergency Contact ☐ No ☐ Yes

Pharmacy Name and Address:

_____
_____
_____

REASON FOR DOCTOR'S VISIT TODAY:(State your primary concern first)

_____
_____

Who are your other doctors?

NAME	**SPECIALTY**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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PAST MEDICAL HISTORY:

☐Cancer: (Type and Treatment) _____	MUSCULOSKELETAL ☐Arthritis ☐Osteopenia/Osteoporosis
CARDIOVASCULAR ☐High Blood Pressure ☐High Cholesterol ☐Stroke/CVA ☐MI/heart attack ☐Vascular Disease ☐Atrial Fibrillation ☐Check if you have a Pacemaker ☐Check if you have a Defibrillator? ☐Heart Problems: What kind? _____	INFECTION/IMMUNOLOGIC ☐Hepatitis ☐Tuberculosis (TB) ☐Immune Disorder ☐Lupus ☐Psoriasis ☐Rheumatoid Arthritis
ENDOCRINE ☐High Thyroid Levels (Hyperthyroid) ☐Low Thyroid Levels (Hypothyroid) ☐Diabetes ☐ Insulin Dependent	GI/GU ☐Kidney Disease ☐Liver Disease ☐Stomach Ulcers ☐Gastric Reflux/GERD
NEUROLOGIC ☐Multiple Sclerosis ☐Epilepsy/Seizures ☐Parkinson's ☐Alzheimer's ☐Drug Abuse/Alcohol Dependence	RESPIRATORY ☐Asthma ☐Bronchitis/Emphysema ☐Pneumonia
BLOOD DISORDER ☐Anemia ☐Bleeding Disorder ☐History of blood clots (e.g. pulmonary embolism and/or DVT)	OTHER CONDITIONS: _____ _____ _____

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List previous hospitalizations, major surgeries, serious injuries and approximate dates:

Surgery/Injury/Hospitalization Date

_____
_____
_____
_____
_____
_____

MEDICATIONS: List all medications you are taking and dosages (prescription and all over-the-counter drugs):

Medication Dosage (e.g. mg) Times/day

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you take Coumadin? ☐ No ☐ Yes: Dosage _____
Do you take Aspirin? ☐ No ☐ Yes: Dosage _____

External treatment History consent (Do you allow the doctor to see the medications that your other doctors had put you on?)

☐ No ☐ Yes

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ALLERGIES: List medication, food, latex and environmental allergies and describe reaction(s):

☐ No known drug allergies

Allergen Reaction

_____
_____
_____
_____
_____

FAMILY HISTORY:

List any health problems in your immediate family:

	Age	Medical Problems	If Deceased: Cause & Age at Death

Father : _____
Mother: _____
Siblings: _____
_____
_____
Children: _____
_____
_____

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SOCIAL HISTORY:

Are you a: ☐Current Smoker ☐Former Smoker ☐Nonsmoker
☐ Smoker in the last 2 years

If you are a current smoker:

How often do you smoke: ☐Every day ☐Not every day

- How many cigarettes per day do you smoke:_____

Did you have an alcoholic beverage in the past year: ☐Yes ☐No

- If yes, how many alcoholic beverages per week: _____

Have you used drugs other than those for medical reasons in the past year?
☐Yes ☐No

If yes, what drug? _____

Birthplace: _____

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Who currently lives at home with you?_____

Do you live in a: ☐house ☐condo ☐assisted living facility ☐ nursing home

☐retirement home

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I have reviewed this form and certify that the responses are correct to the best of my knowledge. I understand that Dr. M. Shamala will bill insurances for which she is a participating provider. I am liable for expenses incurred that are not covered under my insurance plan(s). I understand that Dr. M. Shamala **IS NOT** a MediCal provider. It will be my financial responsibility for any deduction or balance that is owed after Medicare payment, if applicable.
I understand that all co-payments, deductibles, and/or non-covered services are to be paid in full at the time of service.
I hereby authorize the release of any information to my insurance company necessary to process the claims. I hereby authorize my insurance company to make payments directly to Dr. M. Shamala.

_____ _____
Signature of Person Completing this Form Date
Relationship (if other than Patient): _____