

**PATIENT REGISTRATION FORM**

(Please print)

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

Chart #: \_\_\_\_\_

1. Patient's Name: \_\_\_\_\_ 2. Sex:  Male  Female  
Last First Middle

3. Address: \_\_\_\_\_  
 **Not OK to send mail** Street City State Zip

4. Home Phone: ( ) \_\_\_\_\_  **Not OK to call**  
5. Cell/Alternate Phone ( ) \_\_\_\_\_  **Not OK to call**

6. Birth date: \_\_\_\_\_ Mo/Day/Yr  
7. Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

8. Mother's Maiden Name: \_\_\_\_\_ 9. E-mail address: \_\_\_\_\_

10. Marital Status:  Single/Never married  Married  Separated  Divorced  Widowed

11. Are you transgender?  No  Yes If yes:  Male to Female  Female to Male

12. Race:  American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian  Pacific Islander  White

13. Ethnicity  Armenian  Guatemalan  Mexican  Sri Lankan  
 Asian Indian  Hmong  Nepali  Thai  
 Bangladeshi  Honduran  Pakistani  Tongan  
 Cambodian  Indonesian  Pilipino  Vietnamese  
 Chinese  Japanese  Russian  Other (pls. specify):  
 Guamanian or Chamorro  Korean  Salvadorian  
 Laotian  Samoan

14. How did you hear about us?  APHCV Staff  Friend/Family  Fair/Festival  Radio  T.V.  
 Building sign  Business/Agency: \_\_\_\_\_  Newspaper/Magazine: \_\_\_\_\_  Other: \_\_\_\_\_

15. Are you Hispanic / Latino?  Yes  No 16. Birthplace: \_\_\_\_\_

17. Year arrived in U.S.: \_\_\_\_\_  N/A 18. Highest education completed:  Elementary  Jr. High  
 High School  College  Above college  N/A

19. Citizenship:  U.S.  Permanent Resident  Visitor  Other: \_\_\_\_\_

20. Employment Status:  Employed  Unemployed  Student ( Full time  Part time)

21. Preferred language with Clinician: \_\_\_\_\_ 22. Need an interpreter?  Yes  No  
(If patient is a minor, indicate primary language of patient's legal guardian)

23. Are you:  a Veteran?  a Homeless?  a Migrant Worker?  a Disabled: \_\_\_\_\_

24. Occupation: \_\_\_\_\_  Business  Food Service  Health Care  Homemaker  
 Laborer  Retail/Wholesale  Self-employed  Other: \_\_\_\_\_

25. Health Insurance coverage:  None  Medi-Cal/PE  Medicare  Private Insurance: \_\_\_\_\_

26. Spouse/parent(s)/significant others: \_\_\_\_\_  
Relation to patient: \_\_\_\_\_ Phone # (If different than patient): ( ) \_\_\_\_\_

27. Contact in case of emergency: \_\_\_\_\_  
Name Relation Phone

Address City State Zip

Asian Pacific Health Care Venture, Inc.  
**Initial Adult Health History Questionnaire**

<b>What are your main concerns or health needs?</b> List in order of importance to you	<b>MEDICINES:</b> List all meds, herbs, nutritional supplements		
	<b>Medication</b>	<b>Dose</b>	<b>How Often?</b>
<b>ALLERGIES:</b> List any allergies to meds and / or foods			

**PAST MEDICAL HISTORY:** Do you have, or have you ever had in the past, any of the following conditions?  
 Check (✓) each box "yes" or "no" – no straight lines please. *Complete BOTH columns.*

	NO	YES	Comments		NO	YES	Comments
High Blood Pressure				Breast Problems			
High Cholesterol				Cancer (specify)			
Diabetes				Prostate Problems			
Heart attack / Angina / Other Known Heart Problems				Arthritis / Joint Problems			
Stroke				Persistent Back Problems			
Lung Problems / Asthma				Serious Injuries			
Eye / Visual Problems			Corrective lenses	Severe Headaches			
Ear / Hearing Problems				Convulsions / Seizures			
Seasonal Allergies				Skin Problems			
Blood Clots (Leg / Lung)				Thyroid Problems			
Blood Transfusions / Products				Nervous Problems			
Anemia / Blood Problems				Suicide Attempt / Thoughts			
Hepatitis / Liver Problems				Depression			
Stomach / Bowel Problems				Others (please list):			
Hemorrhoids / Colon Polyp							
Kidney / Urine Problems							

**PREVIOUS SURGERIES OR HOSPITALIZATIONS:**

YEAR	ILLNESS / INJURY / SURGERY	HOSPITAL

**HABITS / BEHAVIORS:**

Do you need assistance for **DAILY ACTIVITIES**?    No    Yes    If yes, please check from the following needs:  
 Cooking    Grocery shopping    Dressing    Bed    Using Toilet    Getting up from chair    Taking medication

**DO YOU NOW USE, OR HAVE YOU EVER USED**, the following:

Cigarettes    No    Yes    What? \_\_\_\_\_    How much? \_\_\_\_\_    # years? \_\_\_\_\_    Last use? \_\_\_\_\_  
 Alcohol    No    Yes    What? \_\_\_\_\_    How much? \_\_\_\_\_    # years? \_\_\_\_\_    Last use? \_\_\_\_\_  
 Street Drugs    No    Yes    What? \_\_\_\_\_    How much? \_\_\_\_\_    # years? \_\_\_\_\_    Last use? \_\_\_\_\_

**DO YOU NOW USE, OR HAVE YOU EVER USED** other tobacco products, such as (check all that apply):  
 Chewing Tobacco    Snuff    Bidis    Zarda    Paan Masala    Gutkha or    Other: \_\_\_\_\_ ?

Comments:

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**SYMPTOMS:** Do you have any of the following symptoms? *Complete BOTH columns.*

	NO	YES	Comments		NO	YES	Comments
Unusual heartbeat				Lightheaded / dizzy / faint			
Chest pains				Trouble sleeping too little or too much?			
Night sweats or hot flashes				Problems with sex / pain / bleeding			
Trouble breathing				Weakness			
Frequent cough				Little interest / pleasure doing things?			
Indigestion				Feeling down, depressed, hopeless?			
Abdominal pains				Very often feel moody, agitated overwhelmed			
Unusual weight gain / loss				Has anyone hurt or abused you?			
Constipation / diarrhea				If yes, was it _____ recently? _____ in the past?			
Trouble with urination				How?    Physically    Mentally    Sexually			
Blood in stools or rectum				Other: _____			
Female-abnormal bleeding							

Comments:

**FAMILY HISTORY:** Has any of your family / blood relatives ever had any of the following conditions?  
*Complete BOTH columns.*

	NO	YES	Comment		NO	YES	Comment
High blood pressure				Gastrointestinal problem			
Diabetes or high sugar				Hepatitis / Liver problem			
Heart problems				Alcohol / Drug problem			
Stroke				Mental / Emotional problem			
Cancer				Inherited disorders			
TB or lung problems				Thalassemia or Sickle cell			
Kidney or urine problem				Other: _____			

**SOCIAL HISTORY:**

Marital Status:    Single       Married / Significant Other       Separated       Divorced       Widowed

Number in household: \_\_\_\_\_       Number of children: \_\_\_\_\_

Religious preference (or none): \_\_\_\_\_       Occupation: \_\_\_\_\_

Comments:

**FEMALES ONLY:**

	<b>REPRODUCTIVE HISTORY:</b>
Age of first period?	Have you ever been pregnant?    No       Yes
First day of last NORMAL period (LNMP):	Total number of pregnancies? _____
Length of cycle?       Days of flow?	a) #Live Births: _____    c) #Miscarriages / Abortions: _____
Periods are:       regular       irregular	b) #Still Births: _____    d) #Ectopic / Tubal: _____
Maximum # pads / tampons used in 24 hours? _____	Age at first sexual intercourse: _____
Menstrual cramps: none    mild    moderate    severe	Age at 1 <sup>st</sup> birth: _____    Last Delivery Date: _____
Date of last Pap Smear: _____ Normal:    Yes    No	Number of children now living? _____
Ever had an abnormal Pap Smear?    No       Yes	Are you breastfeeding now?    No       Yes
Date of last Mammogram: _____ Normal:    Yes    No	Did your mother take DES (a hormone) when she was pregnant with you?    No       Yes       Unknown
Comments:	

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

DOB: \_\_\_\_\_

Chart # \_\_\_\_\_

**Asian Pacific Health Care Venture, Inc.**  
**Initial Adult Health History Questionnaire**

<b>RISK ASSESSMENT / SEXUAL HISTORY:</b>			
No sexual experience ever before		Virgin (no previous intercourse)	
Not sexually active at this time		Last sexual relations was _____ months / years ago	
Yes, had sexual activity in the past year		Number of partners in last 12 months: _____	
Sexually active with (check all that apply):    Men    Women    Both    Paid for sex or Prostitute			
Does your sexual partner have other sexual partners?    No    Yes    I don't know / maybe			
Have you had a sexual partner who has had sex with:		an IV drug user    prostitute / paid for sex a person of the same sex	
Have you OR your sexual partner(s) had any infections related to sex?    No    Yes, specify: _____			
Birth Control method you use OR have used in the past: (Check all that apply) MEN answer first line, Women any that apply			
None	Abstinence	Rhythm method	Withdrawal
Pill	Patch	DMPA (Depo)	Norplant
Tubal Ligation	Foam / vaginal insert	Other (specify): _____	
Have any birth control methods caused you problems?    No    Yes, explain: _____			
What method of birth control are you using currently?		Date of last unprotected intercourse: _____	
Comments: _____			
<b>EXERCISE:</b>			
Do you exercise regularly?    No    Yes    If yes, type and frequency (min. per day / week): _____			
<b>DIET:</b>			
Do you have, or have you ever had, an eating disorder or special eating problems?    No    Yes, explain: _____			
Current Dietary Intake:	High	Medium	Low
Fat			Comments
Fiber (Fruit / Vegetables)			
Caffeine			
Salt			
Sugar			
Water / Fluids			
<b>IMMUNIZATIONS &amp; TESTS:</b>			
What vaccinations do you know you have received in the past <i>as an adult or child?</i> (Please check)			
Td / Tetanus	Polio	MMR	Rubella
Influenza	Hepatitis A	Hepatitis B	Varicella
			Pneumovax
			PPD
			HPV
Check here if you received your childhood vaccinations in the U.S.		Check here if you have NOT had any vaccinations	
Have you ever had a positive TB skin test?    No    Yes    If yes, chest X-ray result:    Normal    Abnormal    Year: _____			
Have you ever been treated for TB?    No    Yes    If yes, please answer the following:			
Date of treatment: _____		Name of medication: _____	
		Length of treatment: _____ months	
<b>This form was completed by:</b> Myself, the patient: _____    Today's date: _____			
Staff: _____		Patient signature	
(Name)		Friend / Relative: _____	
		(Name / Relation)	
<b>Reviewed by:</b> _____    Date: _____			
MD: _____		NP: _____	
		PA: _____	

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Nusrat Ahsan, MD        | <input type="checkbox"/> Truong Do, MD            | <input type="checkbox"/> Wipada La, PA-C               | <input type="checkbox"/> Kaewchai Puktarasiri, NP |
| <input type="checkbox"/> James Bon, NP           | <input type="checkbox"/> John Hoh, MD             | <input type="checkbox"/> Diana Lee, MD                 | <input type="checkbox"/> Lena Yu, MD              |
| <input type="checkbox"/> Veronica Castillo, PA-C | <input type="checkbox"/> Julie Howard, MD         | <input type="checkbox"/> Jean O'Neal, NP               | <input type="checkbox"/> Elizabeth Wang, NP       |
| <input type="checkbox"/> Philip Chan, MD         | <input type="checkbox"/> Dominic Koh, CPNP, ANP-C | <input type="checkbox"/> Kathleen Ruchantikhumporn, NP | <input type="checkbox"/> _____                    |
- Per diems, please use personal stamp

Name: \_\_\_\_\_    DOB: \_\_\_\_\_    Chart # \_\_\_\_\_    Page 3 of 3 (08/29/08)