

Saddleback Respiratory Medical Group/ SoCal Respiratory Medical Group
24411 Health Center Drive Suite 560, Laguna Hills, Ca. 92653
949-521-7161

Page 1 Confidential Health Questionnaire

PATIENT QUESTIONNAIRE

PHYSICIAN: _____ TODAY'S DATE: _____

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____
Street City State Zip

HOME PHONE: () _____ WORK PHONE: () _____ EXT: _____

E-MAIL ADDRESS: _____ CELL PHONE: () _____

MARITAL STATUS: (Circle) S M W D SEX: M F

PRIMARY INSURANCE: (see card) _____ SECONDARY INSURANCE: (see card) _____

LANGUAGE: _____ ETHNICITY: _____ RACE: _____

EMERGENCY CONTACT: _____ RELATION TO PT: _____

PHONE #: () _____

YOUR OCCUPATION: _____ EMPLOYER: _____

REASON FOR VISIT: _____

REFERRED BY: _____ YOUR PRIMARY DOCTOR: _____

MAY WE CONTACT YOU AT HOME WITH TEST RESULTS: YES NO

LEAVE A MESSAGE : HOME OFFICE CELLPHONE FAMILY MEMBERS: _____

ADVANCED DIRECTIVE: YES NO WILL PROVIDE REFUSED

HIPAA AUTHORIZATION:

Description of info to be use: all medical information Limited as follows: _____

I authorize Saddleback Respiratory/SoCal Respiratory Medical Group to disclose information.

Person(s) authorized to receive the information: _____

SIGNED, PATIENT (Parent if patient is a minor) _____ DATE: _____

IF OTHER THAN PARENT, RELATIONSHIP: _____

MEDICAL HISTORY: (please \checkmark all those apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Lung Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Obstructive Sleep Apnea | | |

PAST MEDICAL/SURGICAL HISTORY:

Surgery	Year	Hospitalizations	Year

FAMILY HISTORY:

Diagnosis	Family Member	Age	Comments

HEALTH CARE MAINTANENCE:

Test	Year
Chest X-rays	
CT Scan	
Pet Scan	
Sleep Studies	
Pulmonary Testing	
Lab work	

Immunizations	Year
Pneumonia	
Shingles	
Tuberculosis Skin Test	
Flu	
D-Tap	
Tetanus	

SOCIAL HISTORY:

- Tobacco use: current Former Never Passive tobacco exposure
 Type _____ Packs/day _____ Years used _____ Year Quit _____
 Drinks alcohol _____ drinks per month Caffeine use _____

RESPIRATORY MEDICAL HISTORY

1. Were you exposed to dust, gases, or fumes which might make your breathing difficult? YES NO

If yes, explain? _____

2. Do you get short of breath...

With walking? YES NO with grooming? YES NO with showering? YES NO

With bathing? YES NO with bending? YES NO

3. Do you cough? YES NO

4. Do you bring up mucus? YES NO

5. What color is it? _____

How much in 24 hours? Teaspoons: _____ Tablespoons: _____ Cups: _____

6. Do you wheeze? YES NO

Sleep questions: 1. What is the quality of your sleep? _____

2. How many times do you get up to empty your bladder at night? _____

3. Have you been told you snore? YES NO

4. How many hours do you sleep? _____ Hr.

5. Do you feel rested in the morning? YES NO

6. Have you ever been observed to stop breathing at night? YES NO

7. What kind of regular exercise do you do: _____

Do you live alone? YES NO With family? YES NO OTHER: _____

I hereby, assign all benefits to Treating Physician of Saddleback Respiratory/SoCal Respiratory Medical Group for services rendered to me or said minor patient. I authorize any holder of medical information about me or said minor to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to the Treating Physician of Saddleback Respiratory/SoCal Respiratory Medical Group and authorize the release of medical information as necessary to pay the claim. I have given all my insurance information for billing purposes and understand the billing procedures. I understand that I am responsible for all charges not covered by my insurance policy including but not limited to, co-payments, deductibles, and non-covered services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if payment is not made in my behalf by my insurance company.

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (pulmonary studies, x-rays, etc.). These screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings. I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible. I acknowledge my responsibility to notify the office 24 hours prior to any appointment changes or cancellations.

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear form my physician's office within the time specified, I will call the office for my test results.

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that **not** following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide **not** to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

I have been provided a copy of the Notice of Privacy Practices. I have read and understand the information presented in the notice. I understand that I am entitled to receive a paper copy of the notice at any time. I also understand that Saddleback Respiratory Medical Group reserves the right to change this notice and I will be notified of future changes to this notice at my next visit.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

SIGNED, PATIENT (Parent/Legal Guardian if patient is a Minor) _____ DATE: _____

IF OTHER THAN PARENT, RELATIONSHIP: _____

Patient Parking Notice

Due to utility plant construction and the renovation of our Medical Office Tower entrance, patient parking has been relocated until 2028.



To limit inconvenience and provide you with an improved experience, we offer the following parking options for patients and visitors:

Complimentary Valet

Enter off Health Center Drive, and follow the yellow path to the hospital main entrance.

Visitor Parking

Enter off Health Center Drive, and self-park in the visitor area outlined in red.

Thank you for your understanding.

MemorialCare Saddleback Medical Center Medical Office Tower

The Medical Office Tower at Saddleback Medical Center is located just south of the 5 Freeway, adjacent to the Laguna Hills Mall/Five Lagunas Mall.

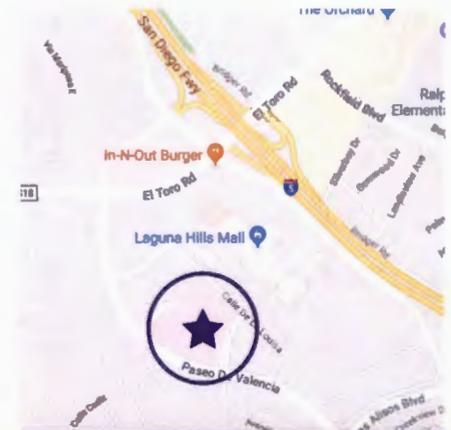
From the 5 Freeway southbound:

Exit at El Toro Road. Continue straight through the intersection. You are now on Paseo de Valencia. Follow Paseo de Valencia to Calle de la Magdalena and turn left. Turn right at the end of the street into the hospital parking lot. Once you park, please take the shuttle or walk up the ramp to the building entrance.

From the 5 Freeway northbound:

Exit at El Toro Road. At the end of the exit ramp, turn left onto El Toro Road. Follow El Toro Road to the third light which is Paseo de Valencia and turn left. Take Paseo de Valencia to Calle de la Magdalena and turn left. Turn right at the end of the street into the hospital parking lot. Once you park, please take the shuttle or walk up the ramp to the building entrance.

Complimentary Valet: We offer free valet for patients and their families Monday – Friday from 7:30 am – 6 pm. Tips are not required. Instead of turning right into the parking lot, continue straight to the roundabout. A shuttle will drop you off at the Medical Office Tower entrance, which also connects to all areas of the hospital. (Wheelchairs available upon request.)



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