Previsit Questionnaire

- To supply the doctor with the information necessary to provide a thorough medical consultation, please complete the form below and return it to us by email, fax, or our MedTunnel portal no later than one week prior to your visit.
- You may download the form and answer the questions by hand or use a PDF filler of your choice.
- The doctor will review your responses in detail before seeing you and prepare materials to discuss during your visit.
- Family history information is especially important for determining genetic risks, so please make sure to complete this and all parts of the form to the best of your ability.
- Our office will check your insurance eligibility and benefits (if applicable) and provide a cost estimate and log-in instructions in advance of your appointment.
- Please remember to review and sign the Telemedicine Consent Form at the end of this document.
- Let us know if you have any questions or need further assistance.

Thank you. We look forward to meeting you.

The Office of Dr. Claudia Mikail

TELEMEDICINE REGISTRATION FORM

VISIT DATE: ______________________________

PATIENT NAME:

____

ADDRESS:

____

____

TELEPHONE NUMBERS

HOME:

WORK:

CELL:

EMAIL ADDRESS: :_________________________________

BIRTHDATE (MO/DAY/YR):_________________

AGE: _______ **SEX AT BIRTH:** ☐ MALE ☐ FEMALE

GENDER IDENTITY:_______________________________

SS#: ____

DRIVER LIC #:____________________________________

PREFERRED LANGUAGE:

____

BEST TIME TO REACH YOU BY PHONE:

MAY WE LEAVE VOICEMAIL MESSAGES? ☐ YES ☐ NO

MAY WE EMAIL YOU HEALTH-RELATED MESSAGES?

☐ YES ☐ NO

RACIAL/ETHNIC ORIGIN

- ☐ AFRICAN
- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN/PACIFIC ISLANDER
- ☐ EUROPEAN
- ☐ HISPANIC
- ☐ MIDDLE EASTERN
- ☐ OTHER:____________________________________

MARITAL STATUS

- ☐ SINGLE
- ☐ MARRIED
- ☐ SEPARATED
- ☐ DIVORCED
- ☐ WIDOWED
- ☐ PARTNERED FOR ___ YEARS

SPOUSE'S INFORMATION (OR PARENT/GUARDIAN INFORMATION FOR MINORS):

NAME:

DATE OF BIRTH:

ADDRESS:

PHONE NUMBERS: (H,W,C):

EMPLOYER:

SS#:

MAY WE SHARE PROTECTED HEALTH INFORMATION (PHI) WITH YOUR SPOUSE? ☐ YES ☐ NO

IN CASE OF EMERGENCY, CONTACT (NAME):____

HOME PHONE:___________________________________ CELL PHONE:______________________________________

WORK PHONE:_____________________________________ RELATIONSHIP TO YOU:______________________________

ACKNOWLEDGMENT: I have received a copy of this medical practice's HIPAA Privacy Practices, Notice to Consumers, and Open Payments Database Notice through their office website: https://www.mikailmd.com

PLEASE SIGN HERE: _________________________________DATE: ______________________

INSURANCE AND BILLING INFORMATION

VISIT DATE:_______________**PATIENT NAME:____________________________________DATE OF BIRTH:___________**

WHO IS RESPONSIBLE FOR THIS ACCOUNT:

NAME:
RELATIONSHIP TO PATIENT:
DATE OF BIRTH:

INSURANCE COMPANY NAME (IF NONE, WRITE “NONE”):
INSURANCE COMPANY ADDRESS:
INSURANCE COMPANY PHONE NUMBER:
GROUP #/POLICY #:

SECONDARY INSURANCE INFORMATION:

IS PATIENT COVERED BY ADDITIONAL INSURANCE? (CIRCLE ONE) YES NO
SUBSCRIBER’S NAME:
SUBSCRIBER’S DATE OF BIRTH:
SUBSCRIBER’S SS#
RELATIONSHIP TO PATIENT:
INSURANCE COMPANY NAME:
INSURANCE COMPANY ADDRESS:
GROUP #/POLICY#:

INSURANCE ASSIGNMENT AND RELEASE: I certify that I (and/or my dependents) have insurance coverage with the insurance company named above (if applicable). Dr. Mikail’s office may disclose my healthcare information to my health insurer and their agents to obtain payment for services and/or determine insurance benefits and/or benefits payable for related services. I authorize the use of my signature on all insurance submissions by Dr. Mikail’s office, to whom I assign all benefit payments for the services rendered.

FINANCIAL RESPONSIBILITY AGREEMENT: I understand that I am financially responsible for all charges by Dr. Mikail’s office. I understand that if I have not paid my insurance premium on time, have not fulfilled my deductible, the services I receive are not covered by my health insurance plan, or my insurer otherwise denies payment for my medical care for any reason, I will be responsible for payment for the services provided. I agree to verify potential charges for any lab tests, imaging, referrals, or other procedures related to my care directly with my health insurer and the service provider before proceeding with those services.

PLEASE SIGN AND DATE BELOW:

____ _____________________

Signature of Beneficiary, Guardian, or Personal Representative Date

____ _____________________

Please print name of Beneficiary, Guardian, or Personal Representative Date

PREVISIT MEDICAL HISTORY AND HEALTH RISK ASSESSMENT FORM

PATIENT NAME:

CURRENT AGE:

BIOLOGICAL SEX: MALE FEMALE

DATE OF BIRTH:

GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ NON-BINARY

(IF A MINOR) PATIENT'S MOTHER'S NAME :

PATIENT'S FATHER'S NAME:

REFERRED BY:

NAME:

ADDRESS:

TELEPHONE NUMBER:

FAX NUMBER:

PRIMARY CARE PHYSICIAN:

NAME:

ADDRESS:

TELEPHONE NUMBER:

FAX NUMBER:

WHY ARE YOU SEEKING A GENETIC EVALUATION?

WHEN DID THIS PROBLEM PRESENT?

WHICH OF THESE GENETIC TESTS HAVE BEEN PERFORMED ON YOU IN THE PAST?

- ❑ CHROMOSOME ANALYSIS (KARYOTYPE)
- ❑ CHROMOSOMAL MICROARRAY
- ❑ FISH TEST
- ❑ WHOLE EXOME SEQUENCING
- ❑ WHOLE GENOME SEQUENCING
- ❑ DNA METHYLATION ANALYSIS
- ❑ MUTATION ANALYSIS
- ❑ CARRIER SCREENING
- ❑ OTHER SPECIALIZED GENETIC STUDY
- ❑ *NONE OF THE ABOVE*

HAVE ANY OF THESE GENETIC TESTS BEEN PERFORMED ON A BLOOD RELATIVE? IF SO, PLEASE LIST THEIR FAMILIAL RELATIONSHIP TO YOU (E.G., MOTHER, SISTER, COUSIN, ETC), NAME OF TEST, AND RESULT:

*****PLEASE FORWARD US OFFICIAL RESULTS OF ALL PERTINENT GENETIC TESTS YOU OR YOUR RELATIVES HAVE HAD*****

WHICH OF THESE OTHER TESTS AND STUDIES HAVE YOU HAD?

- ❑ CT SCAN
- ❑ DEVELOPMENTAL ASSESSMENT
- ❑ ECHOCARDIOGRAM
- ❑ EEG (BRAIN)
- ❑ EKG (HEART)
- ❑ EYE/VISION EXAM
- ❑ HEARING EVALUATION
- ❑ MRI
- ❑ ORGAN BIOPSY
- ❑ OTHER BLOODWORK
- ❑ OTHER STUDIES (LIST HERE):
- ❑ SKIN BIOPSY
- ❑ ULTRASOUND
- ❑ X-RAYS

LIST RESULTS HERE (IF YOU NEED MORE SPACE PLEASE USE THE OTHER/COMMENTS SECTION AT THE END OF THIS FORM):

PRENATAL HISTORY

WHICH OF THE FOLLOWING APPLIED TO THE PATIENT'S MOTHER'S HEALTH DURING HER PREGNANCY WITH THE PATIENT? (MARK ALL THAT APPLY):

- ❑ ABNORMAL FETAL MOVEMENTS
- ❑ ALCOHOL USE
- ❑ BLEEDING
- ❑ CAFFEINE USE
- ❑ CHRONIC ILLNESS
- ❑ DRUG USE
- ❑ EXPOSURE TO CHEMICALS
- ❑ EXPOSURE TO X-RAYS
- ❑ FEVER
- ❑ FOLATE USE BEFORE CONCEPTION
- ❑ INFECTION
- ❑ MEDICATION USE
- ❑ OTHER PREGNANCY COMPLICATIONS
- ❑ PRENATAL VITAMIN USE
- ❑ TOBACCO USE
- ❑ *NONE OF THE ABOVE*

PLEASE EXPLAIN IN MORE DETAIL THE ITEMS YOU HAVE CHECKED OFF:

WHAT PRENATAL TESTING WAS PERFORMED DURING THE PREGNANCY?

- ❑ AFP (OR TRIPLE SCREEN)
- ❑ AMNIOCENTESIS
- ❑ CHORIONIC VILLUS SAMPLING (CVS)
- ❑ GLUCOSE (SUGAR) TEST
- ❑ ULTRASOUND
- ❑ OTHER:_________________

PLEASE DESCRIBE ANY ABNORMAL RESULTS:

BIRTH HISTORY

WAS THE PATIENT BORN:

- ❑ FULL-TERM
- ❑ PREMATURELY (NUMBER OF WEEKS:__________)

MODE OF DELIVERY:

- ❑ VAGINAL
- ❑ C-SECTION (WHY:________________________________)

PRESENTATION:

- ❑ HEAD FIRST
- ❑ BOTTOM FIRST (BREECH)
- ❑ OTHER:

BIRTH WEIGHT: **BIRTH LENGTH:** **HEAD CIRCUMFERENCE:**

AT WHICH HOSPITAL (NAME, LOCATION, COUNTRY)?

APGAR SCORES, IF KNOWN:

BIRTH COMPLICATIONS, IF ANY:

LENGTH OF STAY IN NURSERY:

REASON FOR PROLONGED STAY, IF APPLICABLE:

MEDICAL HISTORY: ***Has the patient had any of the following? If so, when?***

- ❑ ALLERGIES:_________________
- ❑ ANEMIA
- ❑ ANOREXIA
- ❑ ANXIETY DISORDER
- ❑ ASTHMA
- ❑ ATTENTION DEFICIT/ADHD
- ❑ BEDWETTING/SOILING
- ❑ BEHAVIOR PROBLEMS
- ❑ BIPOLAR DISORDER
- ❑ BLEEDING DISORDERS
- ❑ BLOOD TRANSFUSION (WHEN:___________________)
- ❑ CANCER
- ❑ CATARACTS
- ❑ CHLAMYDIA
- ❑ DEPRESSION
- ❑ DIABETES
- ❑ EMPHYSEMA
- ❑ EPILEPSY/SEIZURES
- ❑ FEEDING DIFFICULTIES
- ❑ GLAUCOMA
- ❑ GOITER
- ❑ GONORRHEA
- ❑ GOUT
- ❑ GROWTH PROBLEMS
- ❑ HEARING PROBLEMS
- ❑ HEART DISEASE
- ❑ HEPATITIS
- ❑ HERNIA (TYPE:______________)
- ❑ HERPES (GENITAL)
- ❑ HIGH BLOOD PRESSURE
- ❑ HIGH CHOLESTEROL
- ❑ HIV POSITIVE
- ❑ HYPOTHYROIDISM
- ❑ HYPERTHYROIDISM
- ❑ INFECTIOUS DISEASE
- ❑ IMMUNOLOGICAL DISEASE
- ❑ KIDNEY DISEASE
- ❑ LEARNING DISABILITY
- ❑ LIVER DISEASE
- ❑ LOW BLOOD PRESSURE
- ❑ LOW CHOLESTEROL
- ❑ MANIC DISORDER
- ❑ MIGRAINES
- ❑ MISCARRIAGES
- ❑ MONONUCLEOSIS
- ❑ MOTOR DELAYS
- ❑ MULTIPLE SCLEROSIS
- ❑ MUSCULAR DYSTROPHY
- ❑ PACEMAKER
- ❑ PNEUMONIA
- ❑ PSYCHIATRIC DISORDER
- ❑ SCHIZOPHRENIA
- ❑ STD
- ❑ STROKE
- ❑ SUICIDE ATTEMPT
- ❑ SLEEPING PROBLEMS
- ❑ SPEECH DELAYS
- ❑ SYPHILIS
- ❑ THYROID DISEASE
- ❑ TUBERCULOSIS
- ❑ UNUSUAL HABITS
- ❑ ULCERS
- ❑ VISION PROBLEMS
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

PLEASE EXPLAIN ANY ITEMS MARKED ABOVE:

DESCRIBE ANY CHRONIC MEDICAL ISSUES OR SIGNIFICANT ILLNESSES NOT LISTED ABOVE (IF NONE, WRITE "NONE"):

LIST PRIOR HOSPITALIZATIONS (HOSPITAL, DATE, DIAGNOSIS, TREATMENT) (IF NONE, WRITE "NONE"):

LIST PRIOR SURGERIES (HOSPITAL, DATE, DIAGNOSIS) (IF NONE, WRITE "NONE"):

CURRENT PRESCRIBED OR OVER-THE-COUNTER MEDICATIONS THE PATIENT IS TAKING, INCLUDING DOSES:

LIST ALLERGIES TO MEDICATIONS AND TYPE OF REACTION:

LIST ANY DIETARY RESTRICTIONS: **HOURS OF SLEEP PER NIGHT:**

IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO HOW MANY COVID VACCINES HAS THE PATIENT HAD?

PHYSICIANS INVOLVED IN THE PATIENT'S MEDICAL CARE (NAME/SPECIALITY/LAST VISIT/NEXT VISIT):

SOCIAL HISTORY:*

- ❑ WITH WHOM DOES THE PATIENT LIVE?
- ❑ HOW MANY DAYS A WEEK DOES THE PATIENT HAVE AN ALCOHOLIC DRINK?
- ❑ HOW MANY ON A TYPICAL DAY?
- ❑ HOW OFTEN MORE THAN 6 PER DAY? ☐DAILY ☐WEEKLY ☐MONTHLY ☐ LESS THAN MONTHLY ☐ NEVER
- ❑ HOW MANY CIGARETTES DOES THE PATIENT SMOKE PER DAY? FOR HOW MANY YEARS?
- ❑ HOW MANY CAFFEINATED DRINKS DOES THE PATIENT HAVE PER DAY?
- ❑ ARE ANY OTHER SUBSTANCES USED?

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DEVELOPMENTAL SCREENING (FOR CHILDREN)

AT WHAT AGE WAS THE PATIENT FIRST ABLE TO DO THESE TASKS? IF YOU CAN'T REMEMBER WHEN, BUT YOUR CHILD CAN PERFORM THE TASK, JUST CHECK THE BOX. IF YOU KNOW THE SKILL WAS REACHED LATER THAN NORMAL, WRITE "LATE":

ASK FOR FOOD	SAY FIRST WORD
BABBLE	SAY MAMA/DADA
CRAWL	SIT UNSUPPORTED
CRAWL UP STAIRS	SMILE
ENJOY LOOKING AROUND	TELL HIS/HER NAME AND AGE
FINGERFEED	TELL STORIES
JUMP SKIP	TURN HEAD TO SOUND
LAUGH	USE A SPOON
LIFT CHEST WHILE ON STOMACH	USE A CUP
MANAGE STEPS WITHOUT HELP	USE TWO-WORD COMBINATIONS
NAME COLORS	WALK ALONE
PEDAL A TRICYCLE	WALK ALONG FURNITURE/ WALL
PLAY WITH OTHERS	WALK WITH HANDS HELD
POINT TO BODY PARTS	WAVE BYE-BYE
RAISE HEAD WHILE ON STOMACH	RECOGNIZE PARENTS
RECONGIZE STRANGERS	ROLL OVER
RUN	

LIST THE PATIENT'S GRADE LEVEL IN SCHOOL:

THE PATIENT IS ENROLLED IN:

- ❑ REGULAR CLASSES
- ❑ SPECIAL EDUCATION

THE PATIENT RECEIVES:

- ❑ PHYSICAL THERAPY
- ❑ SPEECH THERAPY
- ❑ ADAPTIVE PE
- ❑ OCCUPATIONAL THERAPY
- ❑ INFANT STIMULATION
- ❑ OTHER THERAPY

HAS THE PATIENT BEEN REFERRED TO A REGIONAL CENTER:

- ❑ YES (WHICH ONE?_______________________________)
- ❑ NO

DO YOU HAVE ANY CONCERNS ABOUT THE PATIENT'S DEVELOPMENT OR SCHOOL PERFORMANCE? ☐ **YES** ☐ **NO**

IF YES, PLEASE DESCRIBE HERE:

EDUCATIONAL/DEVELOPMENTAL/OCCUPATIONAL SCREENING (FOR ADULTS)

WHAT LEVEL OF EDUCATION HAS THE PATIENT ATTAINED?

DOES THE PATIENT HAVE DEVELOPMENTAL DELAY, LEARNING OR INTELLECTUAL DISABILITY, OTHER COGNITIVE IMPAIRMENT, OR BEHAVIORAL DISORDER? IF SO, PLEASE DESCRIBE.

IS THE PATIENT EMPLOYED? ☐ YES ☐ NO

IF SO, WHAT IS THE OCCUPATION?

THREE GENERATION FAMILY HISTORY SCREENING FOR PEDIGREE ANALYSIS

ARE THERE ANY BLOOD RELATIVES WITH A SIMILAR PROBLEM AS THE PATIENT? ☐ YES ☐ NO

IF YES, WHO?

PATIENT'S MOTHER'S MEDICAL HISTORY

CURRENT AGE:
DATE OF BIRTH:
HEIGHT:
NUMBER OF TOTAL PREGNANCIES:
NUMBER OF LIVE BIRTHS:
NUMBER OF MISCARRIAGES:
NUMBER OF STILLBIRTHS:
MEDICAL PROBLEMS:
MEDICATIONS USED:

PATIENT'S FATHER'S MEDICAL HISTORY

CURRENT AGE:
DATE OF BIRTH:
HEIGHT:
MEDICAL PROBLEMS:
MEDICATIONS USED:

ARE THE PATIENT'S MOTHER AND FATHER BLOOD-RELATED (E.G., COUSINS?) ☐ YES ☐ NO

LIST THE PATIENT'S CHILDREN (IF ANY):

NAME	AGE	SEX	HEALTH

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BROTHERS AND SISTERS OF PATIENT

(IF HALF-SIBLINGS, PLEASE NOTE MATERNAL OR PATERNAL) (ADD LINES IF NEEDED)

NAME	AGE	SEX	HEALTH	FULL OR HALF SIBLING

DO THE PATIENT'S BROTHERS AND SISTERS HAVE KIDS?

ARE THEY HEALTHY?

GRANDPARENTS OF PATIENT

RELATIONSHIP	NAME	AGE	ETHNICITY *	HEALTH
MATERNAL GRANDMOTHER				
MATERNAL GRANDFATHER				
PATERNAL GRANDMOTHER				
PATERNAL GRANDFATHER				

***ETHNICITY: Mark if your grandparents or other ancestors are from any of these geographic regions or ethnic groups (relates to the epidemiology of some genetic diseases):**

- ❑ AFRICAN
- ❑ ASHKENAZIC JEWISH
- ❑ ASIAN
- ❑ CARIBBEAN
- ❑ CENTRAL AMERICAN
- ❑ EUROPEAN
- ❑ FILIPINO
- ❑ FRENCH CANADIAN
- ❑ HISPANIC
- ❑ MIDDLE EASTERN
- ❑ MIDDLE EASTERN JEWISH
- ❑ NATIVE AMERICAN/ALASKAN NATIVE
- ❑ PACIFIC ISLANDER
- ❑ PERSIAN JEWISH
- ❑ SEPHARDIC JEWISH
- ❑ SOUTH AMERICAN
- ❑ OTHER:___________________

AUNTS AND UNCLES OF PATIENT

LIST **PATIENT'S MOTHER'S BROTHERS AND SISTERS** (IF HALF SIBLINGS, NOTE MATERNAL OR PATERNAL) (ADD LINES IF NEEDED)

NAME	AGE	SEX	HEALTH	FULL OR HALF SIBLING

LIST **PATIENT'S FATHER'S BROTHERS AND SISTERS** (IF HALF SIBLINGS, NOTE MATERNAL OR PATERNAL) (ADD LINES IF NEEDED)

NAME	AGE	SEX	HEALTH	FULL OR HALF SIBLING

IS THERE HISTORY IN THE PATIENT'S FAMILY OF:

- ❑ ATTENTION DEFICIT/HYPERACTIVITY
- ❑ AUTISM
- ❑ BIRTH DEFECTS
- ❑ CANCER
- ❑ DEVELOPMENTAL DELAY
- ❑ INFERTILITY
- ❑ INTELLECTUAL DISABILITY
- ❑ MISCARRIAGES
- ❑ NEWBORN/CHILDHOOD DEATHS
- ❑ PSYCHIATRIC DISORDERS
- ❑ STILLBIRTHS
- ❑ UNUSUAL FEATURES
- ❑ OTHER DISEASES:
- ❑ NONE OF THE ABOVE

IF YES, PLEASE EXPLAIN IN MORE DETAIL:

SCREENING BY ORGAN SYSTEM

PATIENT HEIGHT:____________________________________ WEIGHT:__________________________________

DOES THE PATIENT HAVE ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS? IF SO, MARK THEM BELOW..

GENERAL

- ❑ FEVER
- ❑ CHILLS
- ❑ SWEATS
- ❑ CHANGE IN WEIGHT
- ❑ FATIGUE
- ❑ TEMPERATURE SENSITIVITY
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

SKIN

- ❑ RASHES
- ❑ EASY BRUISING
- ❑ ECZEMA
- ❑ BIRTHMARKS
- ❑ LUMPS
- ❑ SKIN CHANGES
- ❑ NAIL CHANGES
- ❑ CHANGES IN MOLES
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

EYES

- ❑ REDNESS
- ❑ DISCHARGE
- ❑ CHANGE IN VISION
- ❑ GLAUCOMA
- ❑ CATARACTS
- ❑ EYEGLASSES
- ❑ SENSITIVITY TO LIGHT
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

EARS

- ❑ INFECTIONS
- ❑ RINGING
- ❑ HEARING IMPAIRMENT
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

NOSE

- ❑ BLEEDING
- ❑ FREQUENT COLDS
- ❑ NASAL POLYPS
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

MOUTH/THROAT

- ❑ PROBLEMS WITH TEETH
- ❑ PROBLEMS WITH GUMS
- ❑ FREQUENT SORE THROATS
- ❑ UNUSUAL VOICE
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

NECK

- ❑ GOITER
- ❑ LUMPS
- ❑ PAIN
- ❑ THYROID PROBLEMS
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

CHEST

- ❑ COUGH
- ❑ ASTHMA
- ❑ SNORING
- ❑ PAIN
- ❑ WHEEZING
- ❑ SHORTNESS OF BREATH
- ❑ SHORTNESS OF BREATH WHILE SLEEPING
- ❑ RESPIRATORY PROBLEMS
- ❑ PNEUMONIA
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

HEART

- ❑ PALPITATIONS
- ❑ HEART MURMUR
- ❑ SHORTNESS OF BREATH WITH EXERTION
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

DIGESTIVE

- ❑ BLOOD IN STOOLS
- ❑ CONSTIPATION
- ❑ DIARRHEA
- ❑ EXCESSIVE HUNGER
- ❑ FOOD INTOLERANCE
- ❑ LIVER DISEASE
- ❑ NAUSEA
- ❑ POOR APPETITE
- ❑ STOMACH ACHES
- ❑ SWALLOWING DIFFICULTY
- ❑ THIRST
- ❑ VOMITING
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

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URINARY

- ❑ PAIN ON URINATION
- ❑ BLOOD IN URINE
- ❑ STRONG ODOR OF URINE
- ❑ FREQUENT URINATION
- ❑ BEDWETTING
- ❑ UNUSUAL URINE COLOR
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

MUSCLE/BONE

- ❑ WEAKNESS
- ❑ LIMITATION OF MOVEMENT
- ❑ CRAMPS
- ❑ STIFFNESS
- ❑ JOINT PAIN
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

NEUROLOGIC

- ❑ HEADACHE
- ❑ FAINTING
- ❑ TINGLING
- ❑ MOOD CHANGES
- ❑ SEIZURES
- ❑ SLEEP DISORDERS
- ❑ DIZZINESS
- ❑ TREMORS
- ❑ UNSTEADY GAIT
- ❑ TICS
- ❑ NUMBNESS
- ❑ SPEECH DISORDER
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

PSYCHIATRIC**

- ❑ LOSS OF INTEREST IN ACTIVITIES
- ❑ DIFFICULTY CONCENTRATING
- ❑ FEELING DEPRESSED/HOPELESS
- ❑ MOVING/SPEAKING MORE SLOWLY
- ❑ FEELING RESTLESS/FIDGETY
- ❑ WANTING TO HURT YOURSELF OR OTHERS
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

GYN (FOR FEMALES)

- ❑ CURRENTLY PREGNANT? YES NO UNSURE
- ❑ IF YES, HOW MANY WEEKS?
- ❑ NUMBER OF PREGNANCIES:
- ❑ NUMBER OF LIVE BIRTHS:
- ❑ NUMBER OF MISCARRIAGES:
- ❑ NUMBER OF STILLBIRTHS:
- ❑ AGE AT FIRST PERIOD (MENARCHE):
- ❑ DATE OF LAST MENSTRUAL PERIOD:
- ❑ PROBLEMS WITH PERIODS (DESCRIBE):
- ❑ OTHER GYNECOLOGICAL PROBLEMS (DESCRIBE):
- ❑ PLAN ON BECOMING EGG DONOR
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

UROLOGICAL (FOR MALES)

- ❑ LOW SPERM COUNT
- ❑ OTHER UROLOGICAL PROBLEMS
- ❑ MULTIPLE MISCARRIAGES IN FEMALE PARTNER
- ❑ PLAN ON BECOMING SPERM DONOR
- ❑ OTHER:
- ❑ NONE OF THE ABOVE

OTHER/ADDITIONAL COMMENTS

***THIS FORM WAS COMPLETED BY:*____ *DATE:*____________**

***REVIEWED BY PHYSICIAN:*____ *DATE:*____________**

**Based on AUDIT-C Screening Tool*
***Based on PHQ-9 Screening Tool*

TELEMEDICINE CONSENT FORM

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self-management and caregiver support of the patient. Telemedicine services often provides a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

Terms and Consent to Use Telemedicine

I attest that I am physically located in California.

At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication.

By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor’s staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with an available doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to “autoremember” usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. I agree to be photographed during telemedicine services for identification or clinical documentation purposes, if applicable. I understand the resulting image will become part of my medical record. No video or audio recording will be made without my consent.

I read and understand the information provided in this document. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

____ ____________________________

Patient Name and Signature **Date**