Wynnshang Sun, M.D.
9850 Genesee Avenue • Suite 870
La Jolla, California 92037 • (858) 452-7040

Name ____ Date of Birth ___________

The purpose of this questionnaire is to gather information concerning your health and physical condition, both now and in the past. **This information is confidential.** Please answer all the following questions fully and completely as best as you can. If you don't understand a question, be sure to mark it so the doctor can go over it with you during the exam.

Demographics and Heredity

What is your ancestry? Please check each box for which your ancestry is 25% or greater.			
White, not of Hispanic origin		Asian	
Black, not of Hispanic origin		American Indian	
Hispanic		Pacific Islander	
Other (please specify)			

In what country were you born? ____

What type of work do you do? ____

Are you retired? ______ If so, what type of work did you do? _________________________

Please list your hobbies, sports, and activities: ______________________________________

Please check off one circle for each question below:

I am currently: O married O separated O divorced O widowed O never married
O in a committed long-term relationship

I have been married: O 0 times O 1 time O 2 times O 3 or more times

I am currently living: O alone O with my spouse O with my family O with a companion

My highest level of education is: O elementary school O some high school
O high school diploma or GED O some college O college degree or higher

GENERAL HEALTH

I consider my health to be: O excellent O good O fair O poor

The amount of stress I am under is: O small O moderate O large O overwhelming

In the past 12 months
I have been to a doctor: O 0 times O 1-4 times O 5-9 times O 10 or more times

I have had to stay overnight in the hospital: O 0 times O 1 time O 2 or more times

I regularly use seat belts in the car: O Yes O No

I currently have severe fatigue, tiredness or exhaustion: O Yes O No

I often:	Y	N
awaken tired after adequate sleep	O	O
fall asleep at inappropriate times	O	O
am anxious or nervous	O	O
am worried about being ill	O	O
am irritable	O	O
feel like crying	O	O
feel hopeless or down in the dumps	O	O
have problems with depression	O	O
feel suicidal	O	O
have attacks of feeling panicked	O	O

I have:	Y	N
problems controlling anger	O	O
difficulty caring for myself	O	O
frequent headaches	O	O
trouble falling or staying asleep	O	O
Do you have an Advanced Directive (Living Will, Durable Power of Attorney for Health Care, or Directive to Physicians)?	O	O

NEUROLOGIC

Do you had or do you have:	Y	N
trouble with your balance?	O	O
a fall within the past year?	O	O
trouble walking?	O	O
trouble remembering?	O	O
problems with dizziness?	O	O
ever been knocked unconscious?	O	O
involuntary movements of your body?	O	O
a convulsion or seizure?	O	O
numbness in your hands or feet?	O	O
hand/foot paralysis for >5 min?	O	O
a temporary loss of speech?	O	O
a temporary loss of vision ?	O	O
a stroke?	O	O
hallucinations at times?	O	O
a nervous breakdown?	O	O
a brain, nerve, or emotional problem not on this list?	O	O

Y N

EYES

Have you had or do you have:	Y	N
blurry vision?	O	O

	Y	N
double vision? (not blurred)	O	O
visual spots / floaters?	O	O
color blindness?	O	O
A spot in your vision?	O	O
A sudden loss of vision?	O	O
A blind eye?	O	O
a glass eye?	O	O
itchy eyes?	O	O
eye pain?	O	O
cataracts?	O	O
a retinal hemorrhage?	O	O
macular degeneration?	O	O
a detached retina?	O	O
glaucoma?	O	O
an eye problem not on this list?	O	O

EARS

Have you had or do you have:

	Y	N
trouble hearing?	O	O
prolonged exposure to loud noise?	O	O
tinnitus (ringing) in your ears?	O	O
a hearing aid that you use?	O	O
frequent ear infections?	O	O
a draining ear?	O	O
a serious ear injury?	O	O
an ear problem not on this list?	O	O

NOSE/SINUSES

Have you had or do you have:

	Y	N
hay fever or allergic rhinitis?	O	O
frequent sneezing, nasal watering or nasal congestion?	O	O
mucus often draining from your nose?	O	O
frequent nose bleeds?	O	O
nasal polyps?	O	O
nasal problem not on this list?	O	O

MOUTH, THROAT, NECK

Have you had or do you have a:

	Y	N
lip problem?	O	O
tooth or gum problem?	O	O
mouth, tongue, or jaw problem?	O	O
thyroid disease?	O	O
swallowing problem?	O	O
voice problem?	O	O
problem with back of your throat?	O	O

lump or swelling in neck?	O	O
neck pain?	O	O
a mouth, throat, or neck problem not on this list?	O	O

LUNGS

Have you had or do you have:	Y	N
wheezing?	O	O
Shortness of breath?	O	O
A chronic cough?	O	O
coughing up blood in the past year?	O	O
Asthma?	O	O
Emphysema?	O	O
Repeated episodes of pneumonia?	O	O
Tuberculosis?	O	O
Pulmonary embolism (blood clot lung)?	O	O
Chronic bronchitis?	O	O
Collapsed lung?	O	O
Sarcoid?	O	O
Frequent night sweats?	O	O
A lung or chest problem not listed?	O	O

	Y	N
I have been a cigarette smoker	O	O
if yes, do you currently smoke?	O	O

If yes, how many cigarettes do you smoke now every day? ____________

If yes, how many years have you smoked? ________

	Y	N
I have used other tobacco products	O	O

if yes, which ones: O cigars O pipe O snuff O chewing tobacco

	Y	N
are you currently using any of these?	O	O

If yes, how many times per day? ________

I have:	Y	N
received BCG vaccine (TB immunization)	O	O
had a positive TB skin test	O	O
taken INH for at least 6 months	O	O
received Pneumovax (pneumonia shot)	O	O

CARDIOVASCULAR

Have you had or do you have:	Y	N
high blood pressure?	O	O
a cholesterol problem?	O	O
a heart valve problem?	O	O
an abnormal treadmill test?	O	O
a coronary arteriogram?	O	O
angina pectoris (heart pains)?	O	O
a silent heart attack?	O	O
congestive heart failure?	O	O
abnormal blood clot formation?	O	O
a heart attack for which you were hospitalized more than three days?	O	O
a "clot buster" treatment for a heart attack?	O	O
varicose veins?	O	O
narrowing of the arteries in your neck?	O	O
a heart or circulatory problem not listed here?	O	O

Do you get:	Y	N
pressure or tightness in your chest, with exertion or walking uphill?	O	O
pain in the legs that forces you to stop walking?	O	O
episodes of rapid/irregular heartbeat?	O	O
have you ever had abnormal blood clots develop?	O	O

SKIN

I have:	Y	N
a mole that has changed color or size	O	O
a sore that doesn't heal	O	O
acne	O	O
eczema	O	O
psoriasis	O	O
allergy to sunlight	O	O
allergy to cosmetics or chemicals	O	O
allergy to medications	O	O
If yes, please list ______________________		
history of radiation treatment	O	O
darkening of the skin	O	O
a skin condition not listed	O	O

DIGESTIVE

During the last year I have had:	Y	N
distinct weight gain or loss	O	O
trouble swallowing	O	O
indigestion or heartburn	O	O
recurrent nausea or vomiting	O	O
During the last year I have had:		
recurrent abdominal pain	O	O
an episode of vomiting blood	O	O
a change in bowel habits	O	O
frequent diarrhea	O	O
chronic constipation	O	O
visible blood in bowel movement	O	O
black, tar-like, bowel movements	O	O
inability to control my bowels	O	O
a digestion problem not on this list	O	O
I have been diagnosed by a doctor with:		
esophagitis or esophageal reflux	O	O
hiatal hernia	O	O
liver trouble	O	O
gallbladder problems	O	O
peptic ulcer	O	O
gastrointestinal bleeding	O	O
irritable bowel syndrome	O	O
intestinal polyps	O	O
abdominal hernia (rupture)	O	O
	Y	N

I have been diagnosed by a doctor with:

	Y	N
hemochromatosis	O	O
hepatitis	O	O
diabetes or borderline diabetes	O	O
a gastrointestinal problem not on the list	O	O

In the past 10 years I have had a:

	Y	N
barium enema	O	O
colonoscopy	O	O
sigmoidoscopy	O	O

I am:

	Y	N
a vegetarian	O	O
a strict vegetarian who also avoids fish and dairy	O	O

likely to have some form of alcohol:

O never O hardly ever O < 3 times a week
O > three times per week O daily

	Y	N
I sometimes wonder if I drink more than is good for me	O	O
Was there ever a time when you often drank five or more drinks a day of any kind of alcoholic beverage?	O	O

SURGERY

Have you had any of the following surgical operations:

	Y	N
prostate surgery?	O	O
vasectomy?	O	O
breast biopsy?	O	O
lumpectomy?	O	O
mastectomy?	O	O
breast implants?	O	O
tubal ligation?	O	O
hysterectomy?	O	O
bladder surgery?	O	O
abdominal aortic aneurysm?	O	O
angioplasty?	O	O
appendectomy?	O	O
cholecystectomy (gallbladder)?	O	O

Have you had any of the following surgical operations:

	Y	N
coronary bypass?	O	O
carpal tunnel release?	O	O
eye or ear surgery?	O	O
heart valve replacement?	O	O
hernia repair?	O	O
kidney surgery?	O	O
peptic ulcer surgery?	O	O
thyroid surgery?	O	O
artificial joint implant?	O	O
disc or other back surgery?	O	O
other bone surgery?	O	O
surgery not on this list?	O	O

Have you ever been diagnosed with the following cancers?

	Y	N
lung?	O	O
blood or lymphatic?	O	O
bladder?	O	O
colon?	O	O
skin?	O	O
breast?	O	O

cervix?	O	O
uterus?	O	O
ovary?	O	O
	Y	N

testicle?	O	O
prostate?	O	O
Any other cancer? ____________________		

MUSCULOSKELETAL

	Y	N
I have had:		
a leg fracture	O	O
a fracture of the pelvis	O	O
a fracture other than listed	O	O
a bone or ligament injury that never healed	O	O
polio	O	O
I currently have:		
night time leg cramps	O	O
pain or stiffness in my joints on most days	O	O

	Y	N
a musculoskeletal problem not on this list	O	O
I have been diagnosed with:		
rheumatoid arthritis	O	O
osteoarthritis	O	O
psoriatic arthritis	O	O
other forms of arthritis	O	O
osteoporosis	O	O
lupus	O	O
fibrositis or fibromyalgia	O	O

MEN'S HEALTH

	Y	N
I have had:		
prostatitis	O	O
a kidney stone	O	O
I currently have:		
problem starting or stopping urine	O	O
occasional loss of urine	O	O
reduced urine strain	O	O
to get up several times each night to urinate	O	O

	Y	N
pain or burning with urination	O	O
blood in urine	O	O
problems getting an erection	O	O
problem with impotence or maintaining an erection during sex	O	O
a urinary, sexual, or men's health problem not on this list	O	O

WOMEN'S HEALTH

	Y	N
I have a:		
lump in my breast	O	O
nipple discharge	O	O
problem with breast tenderness or pain	O	O
has your physician ever recommended that you have a mammogram?	O	O

My last mammogram was ________________

How often do you do your own breast exam? ___________________________

	Y	N
I have had:		
a breast biopsy or aspiration that was NOT cancer	O	O
a lumpectomy for cancer	O	O
a mastectomy for cancer	O	O
fibrocystic breast diagnosis	O	O
a breast problem not on the list	O	O
I have:		
vaginal itching	O	O
a vaginal discharge	O	O
vaginal dryness	O	O
pain with intercourse	O	O
chronic pelvic pain	O	O
I am:		
currently pregnant	O	O
still having menstrual periods	O	O
definitely in menopause	O	O
not certain about my present state	O	O
I currently have:		
no periods	O	O
regular periods	O	O
irregular periods	O	O
heavy periods	O	O
a lot of pain with my periods	O	O
bleeding or spotting between periods	O	O
vaginal spotting after I thought menopause had started	O	O
I have:		
loss of urine	O	O
pain or burning with urination	O	O
had blood in my urine	O	O
to urinate frequently	O	O
repeated urinary infections	O	O
a urinary problem not on this list	O	O
I have had:		
an infected tube, PID, or other pelvic infection	O	O
glomerulonephritis	O	O
ectopic pregnancy	O	O
a kidney stone	O	O
pyelonephritis	O	O

my last Pap smear was ___________________

what type of birth control do you currently use

____

how many pregnancies have you had _______

how many births have you had _____________

	Y	N
I have had:		
reproductive, urinary, or sexual problems that are not mentioned	O	O
abnormal blood clots during pregnancy	O	O
other abnormal blood clots in the past	O	O
to be taken off the pill because of clotting problems	O	O

FAMILY HISTORY

I am:	Y	N
adopted	O	O
an identical twin	O	O
One of my children has serious health or emotional problems	O	O
Some primary members of my family died before age 65	O	O

I have _____ brothers

I have _____ sisters

Please check any appropriate boxes. **The following have occurred in my biologic family:**

	Mother	Father	Brothers	Sisters	Children	Grandparents
Heart attack						
High blood pressure						
Diabetes						
Cancer						
Stroke						
Abnormal blood clots						
Alcoholism						
Illegal or street drug use						
Liver problems						
Any rare hereditary disease						
Depression						
Suicide						
Serious health or emotional problem						
If deceased, please write the age in which they died						

SOCIAL/SEXUAL HISTORY

Important: This information is **confidential**. It will be placed in a section of your medical chart that cannot be duplicated if your medical record is ever copied for health companies, employers, etc. This information is helpful for your medical treatment, but if you do not feel comfortable filling out any section, you may leave it blank.

	Y	N
I am:		
a virgin	O	O
not sexually active within the past year	O	O
no longer sexually active	O	O
sexually active with a male partner	O	O
sexually active with a female partner	O	O
sexually active with more than one partner at this time	O	O
satisfied with my sex life	O	O
I am:		
possibly at risk for AIDS	O	O
diagnosed with HIV/AIDS	O	O
I have had:		
urethritis	O	O
genital herpes	O	O
gonorrhea	O	O
syphilis	O	O
a sexually transmitted disease not on this list	O	O

	Y	N
I have:		
been physically abused as a child	O	O
been verbally abused as a child	O	O
been sexually molested as a child or adolescent	O	O
been raped	O	O
been threatened or abused as an adult by a sexual partner	O	O
Has your partner ever threatened, pushed, or shoved you?	O	O
Have you ever threatened, pushed, or shoved your partner?	O	O
Have you ever had a partner threaten or abuse your children?	O	O
I am having serious problems with:		
my marriage	O	O
my family	O	O
my job	O	O
finances	O	O
drug or alcohol use	O	O
work-related injuries	O	O
have you ever used street drugs, even one time?	O	O

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Patient Registration

Name ____ Home phone (_____) ____________________

Address ____ Cell phone (_____) ______________________

City/State/Zip ____

Social Security Number _____________________________ Date of Birth __________________________________

Employer ____ Work phone (______) _________________________

Emergency Contact __________________________________ Relation _____________________________________

Address ____ City/State/Zip __________________________________

Phone Number (_____) _________________________ Referred by _____________________________________

Insurance and Billing Information

Insurance Company ______________________________ Address ____

Subscriber Name __________________________ I.D. # _______________________ Group # __________________

Insurance Company ______________________________ Address ____

Subscriber Name __________________________ I.D. # _______________________ Group # __________________

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Dr. Sun, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Dr. Sun to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicare/Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original

Patient Name ____ Date ________________________

Patient Signature ____

It is our office policy to try to contact every patient by phone whenever follow-up information needs to be given for test results, further care needs, etc. Most of these calls will be made during business hours, and we often encounter only message machines or voice mail when we make calls. Please provide the telephone number that you would prefer us to use to contact you about your medical information and needs.

Daytime Telephone (_______) __________ - _____________

Please check one of the following to indicate your wishes:

______ 1. Dr. Sun or his staff may leave medical information on my answering machine or voice mail. This may include test results, diagnosis, and recommendations

Or

______ 2. I would like Dr. Sun or his staff to leave only a message to return their call. I acknowledge that this may delay my receipt of important information

Signed ____ Date ____________________

ELECTRONIC MAIL

In addition, we may soon be implementing e-mail as a means to communicate certain specific information. This may include appointment reminders, cholesterol and diabetes test results, or perhaps other laboratory results. Significantly abnormal results will still be communicated by telephone. Additionally, the law states that information regarding hepatitis testing, HIV antibody testing, the abuse of drugs, and tests of body tissues such biopsies or Pap smears, can never be transmitted by e-mail. You must realize, however, that **email is not a secure means of communication, and it may reach sources other than those you intend.** Also, please do not provide a work e-mail address, as all company e-mail is usually saved on work computers regardless of whether the message has been erased, and your medical information should not be readily available to your employer. Please check one of the following:

______ 1. I prefer not to use e-mail for communication

Or

______ 2. When it becomes available, I would like Dr. Sun or his staff to contact me by e-mail for appointment reminders, test results, and recommendations. I understand that e-mail is not a totally secure means of information transmission

Home e-mail address (please print) ____

Signed ____ Date ____________________

Wynnshang C. Sun, M.D., APC
9850 Genesee Avenue • Suite 870
La Jolla, California 92037 • (858) 452-7040

Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services.

Uses And Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of physicians practice, and any other use required by law.

Treatment: we will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to, in order to ensure that the physician has all necessary information to diagnose or treat you.

Payment: Your PHI will be used, as necessary, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant PHI be disclose to the health plan to obtain approval for the hospital admission.

Health care operations: we may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointments.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements;

Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activities; Military Activity and National Security; Workers' Compensation; Inmates; and Required Uses And Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses And Disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You will then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer. We will not retaliate against you for filing a complaint.

Wynnshang C. Sun, M.D., APC
Diplomate, American Board of Internal Medicine
9850 Genesee Avenue • Suite 870
La Jolla, California 92037

Telephone (858) 452-7040 | Facsimile (858) 452-7137

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

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: ____

____

____

Complete the following only if the patient refuses to sign:

Reasons for refusal: ____

____