NAME: _____ APPT DATE: _____ TIME: _____

Last Initial

REFERRING MD: _____

( ) MAILED HISTORY FORM: _____

( ) RECEIVED HISTORY FORM _____

( ) RECEIVED MD REFERRAL _____

( ) DPX ALSO

( ) PATIENT TOLD TO COME 1/2 HOUR EARLY TO COMPLETE FORMS

NOTE ***We Are a " FRAGRANCE FREE OFFICE***

We are a "FRAGRANCE FREE OFFICE"
Please see our Office Policy for Details.

2024

Robin K Dore MD Inc
12791 Newport Ave., Suite 201, Tustin CA 92780
(714) 505-5500 FAX (714) 505-3381

Dear _____ Appointment Date: _____, 2024 ____ am _____ pm

You are scheduled for an appointment. **These are our policies**:
See our "Fragrance Free" Office Policy
Referral required.
You must have a **referral** from your **treating physician** stating the reason for the referral. This can be a faxed prescription referring you to this office.

This office only provides **adult** (usually 30 and older) **rheumatology care** for arthritis and related auto-immune diseases; osteoporosis care may also be provided. ***Patients are not seen for*** "second opinions."

You **must** have a **primary physician** for your general medical (and emergency) care as well as routine physical exams. For example, your primary physician is responsible for your routine screening for various diseases, such as for breast, cervical, colon and prostate cancer. Breast, genitourinary and rectal examinations are not performed by Dr. Dore as part of her rheumatology care.

Forms to complete.
Fully complete, sign and return a **week** prior to your appointment the enclosed: patient history, financial responsibility statement and insurance billing authorization. We reserve the right to cancel appointments if the forms have not been received.

Bring/Send medical records.
Bring/Send any lab results, x-ray reports or other information relating to your disease. Ask your doctor in writing to send records here. Records may be sent via fax or email: info@robinkdoremd.com

Payment.
Payment in full is required at the time services are rendered for any **"Out of Network"** Patient. You will receive a receipt showing the treatment, charge and diagnosis. You can use this to seek insurance reimbursement. **Medicare and Blue Shield** of ***California*** PPO(Commercial Plans) patients are responsible for deductibles and co-payments deemed by your insurance company as Patient Responsibility – these are paid at visits.

Credit Cards Accepted: Visa, AMEX and MasterCard **ONLY**.

Insurance billing.
Except for Medicare and **Blue Shield of California PPO (Commecial Plans Only). Dr Dore is NOT a Prefered Provider for any Blue Shield PPO "Individual/Family Plans" -IFPs)**, we do not bill insurance except as a courtesy – and only to those insurers we already submit to electronically.

Patients are responsible for amounts not paid by their insurer for medical services. ***Medicare*** patients please note: We may bill your secondary insurance(s). You may have to pay any amount not paid by your secondary insurance(s).

Communication: Our office may communicate with our patients by telephone and/or electronic methods, such as our: **Patient Portal**.

Please Bring Your Insurance Card(s) to your appointment.
If you are faxing/mailing your completed New Patient Packet, please include your insurance card(s) with your forms.

No IPAs/HMO/"Senior" Plans/ PPOs/Covered CA/Exchange.
This office is **NOT** a member of **any** independent physician organization (IPA), HMO, "senior plan" or preferred provider organization (PPO) or ANY Covered CA/Exchange Plans. **Exception: Blue Shield of CA PPO (Commercial Plans-ONLY). Dr Dore is considered "Out of Network" for all Blue Shield of CA "Individual/Family Plans", eg, Platinum, Gold, Silver Plans, etc… It is the patient's responsibility to call and confirm with their own insurance plan to confirm.**

No Primary Medi-Cal, Medicare/Medi-Cal, or Cal Optima
This office does **not** see Patients with these coverages. We reserve the right to stop seeing Medicare patients if their Medicare becomes secondary.

No Workers' Compensation or accident / lawsuits.
This office also does not see new patients with injuries, job related or otherwise, or problems which may involve a pending or potential lawsuit.

Any new patient with an injury, accident or problem involving an existing or potential lawsuit or workers compensation claim will not be seen and any visit will be terminated upon disclosure of such matters.

***Please: Do not wear anything scented (perfume, cologne, body powder, after shave lotion, etc.) to the office.** Dr. Dore is **highly allergic** to these items. If you wear any such items your appointment may be canceled. You would have to reschedule. **See our "Fragrance Free" Office Policy**.

Cancellations. If you cannot keep this or any other appointment, please advise us as early as possible. We reserve the right not to reschedule patients who cancel.

Call **the office** if you have any questions about our policies.
714-505-5500. email: info@robinkdoremd.com

Dr. Dore is a board certified rheumatologist. She is a Clinical Professor of Medicine at UCLA, and lectures house staff at Harbor-UCLA Medical Center.In addition to her practice, Dr. Dore is a paid speaker, consultant and/or researcher for pharmaceutical companies regarding medications prescribed by physicians, including her.She is also a paid consultant to other companies, including prescription benefit plans. Document1

Robin K. Dore, MD, Inc. **PATIENT FINANCIAL RESPONSIBILITY AGREEMENT**

Full payment is required from you at the time of the office visit for all Primary insured **"Out of Network"** Patients.
Blue Shield of CA Plans, Medicare and Medi-Cal patients must pay any applicable deductible, co-payment or share of cost.) We are **NOT** a member of any preferred provider organization (except Dr. Dore is a California Blue Shield PPO preferred provider for **Commercial Plans only**) or independent physician association (IPA) or HMO. We will file primary Medicare claims. We will bill third party coverage as a courtesy if already do so electronically. However, you are responsible for any amount not paid except where applicable federal or state laws limit patient's responsibility.

Name		**Cell / Mobile No:**		
Address		**Home No:**		
City		**Last 4 of SSN**		**Sex:**
State/Zip		**Birth Date**		
Marital	**( ) Single ( ) Married ( ) Divorced ( ) Widowed/Widower**			
Patient Employer	**| Patient e-mail address:**			
Spouse	**| Primary Pharmacy Name/Phone:**			
Spouse Employer		**Spouse Work Tel**		
Friend/relative (other than spouse) to call in emergency:				
Friend/relative Tel		**Relationship**		
Primary Insurance		**Secondary Ins**		
Policy No		**Policy No**		
Group No		**Group No**		
Policyholder		**Policyholder**		
Primary MD		**Tel**		
Orthopedist		**Tel**		
Gynecologist		**Tel**		
Other		**Tel**		

Adult (usually 30 or older) rheumatology consultation and treatment are provided solely for arthritis and related auto-immune diseases; osteoporosis care is provided for some patients. Therefore, it is required that all patients have a primary care physician (internist, family or general practitioner) and appropriate specialists for their other medical problems and for emergencies.

You must see your primary physician for routine physical examinations, including appropriate screening for various diseases, including screening for breast, cervical, colon and prostate cancer, all of which can be fatal if undetected. Breast, genitourinary and rectal examinations are not performed by our physicians as part of providing rheumatology care.

We encourage you to discuss fees prior to your appointment to avoid any misunderstandings.

Our fees are for Rheumatology consultation and care and for any x-ray or lab services done in our office. Any additional studies (lab, xray, EMG, MRI, CT scan, etc.) not done in our office will be billed directly to the patient by the appropriate outside lab, physician or x-ray facility that does those tests.

AGREED TO:
Patient Sign:
_____ Date: _____

Robin K. Dore, MD, Inc. **INSURANCE AUTHORIZATION AGREEMENT**

The patient hereby provides **Robin K. Dore, MD, Inc**. with the following authorizations relating to insurance, Medicare and/or other coverage available to the patient; such authorizations shall apply to past, present and future services furnished by **Robin K. Dore, MD, Inc.**

Authorization of Payment of Benefits

I authorize payment directly to: **Robin K. Dore, MD, Inc.,** for services furnished to me. I will pay all charges not fully paid by insurance, Medicare and/or other coverage. I authorize release of my insurance information to a lab or other outside facility so they can bill my insurance directly for their services.

Signature: _____ Date: _____

Authorization to Release Information

I authorize, **Robin K. Dore, MD, Inc**. (and all physicians employed thereby) to release any information acquired in the course of my examination and treatment to my insurer, Medicare and/or provider of other coverage.

Signature: _____ Date: _____

(1) Medicare Authorization and (2) Medicare Authorization for Prolonged Treatment (YE 12/31/2024) and (3) Addendum

Medicare Authorization
I request that payment of authorized Medicare benefits be made either to me or on my behalf to: **Robin K. Dore, MD, Inc**. for any services furnished my by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

Medicare Authorization for Prolonged Treatment (YE 12/31/2024)
I request that payment under the medical insurance program be made either to me or to **Robin K. Dore, MD, Inc**. on any bills for services furnished me by **Robin K. Dore, MD, Inc.** and/or **Robin K. Dore, MD**, during the period **OCTOBER 1, 2023** TO **DECEMBER 31, 2024**.

Medicare HMO Addendum
I know that Robin K. Dore, MD is **NOT** a member of <u>any</u> Medicare HMO and if I belong to or sign up for a Medicare HMO, I must pay Robin K. Dore, MD for her services. It is my choice to see Dr Dore (and pay) or go to a rheumatologist on my HMO plan.

MEDICARE No: _____

Signature: _____ Date: _____

Group: Robin K. Dore , M.D., Inc.

Robin K. Dore, M.D., Inc.
12791 Newport Ave., Suite 201 Tustin CA 92780

HEALTH HISTORY QUESTIONNAIRE FOR PATIENTS SEEKING TREATMENT FOR ARTHRITIS AND RELATED DISEASES

Appointment Date: Time:		Race: [] White [] African American [] Asian [] Hispanic [] Other:	Ethnicity: [] Non-Hispanic [] Hispanic
Name: Age:		Date of Birth:	Sex □ Male □ Female
Referred by: □ Self □		who is □ MD □ Friend □ Health professional □ Other	
Your primary physician:		The names of your other types of doctors listed below	
Orthopedic Surgeon □ None □		Gynecologist □ None □	
Date of Last →	Physical Exam:	Chest X-ray:	Pap Smear:
Dental Exam:	Lab Tests:	Eye Exam:	Mammogram:

□ Yes □ No Is your problem work related?
□ Yes □ No Do you have any injury, accident or problem - with an existing or potential lawsuit?
□ Yes □ No Are you receiving or applying for disability?
□ Yes □ No Are you receiving or applying for workers compensation?

HISTORY OF PRESENT PROBLEMS: What Brings you to a Rheumatologist?

Began: **Describe your symptoms**

COVID-19 History: **Describe your symptoms:**

Joints: □ Swelling	□ Pain when move	**Muscles**: □ Pain when used □ Weakness □ Tender to touch
□ Tender to touch	□ Reduced movement	**Morning stiffness** - for how long:

Joints affected in the last 6 months:

Muscles affected in the last 6 months:

Who have you seen for this problem? □ No one

Have you seen a rheumatologist ? □ No Who? When?

Were you given a diagnosis? □ No What? When?

WHAT TREATMENT DID YOU HAVE?	Was it Effective?		Was it Effective?
□ Acupuncture	□ Yes □ No	□ Medication (List pages 3 and 4)	□ Yes □ No
□ Appliance (cane, walker)	□ Yes □ No	□ Physical therapy	□ Yes □ No
□ Biofeedback	□ Yes □ No	□ Psychological counseling	□ Yes □ No
□ Chiropractor	□ Yes □ No	□ Surgery (List next page)	□ Yes □ No
□ Joint injected or Aspirated	□ Yes □ No	□ Trigger point injection	□ Yes □ No
□ Other:	□ Yes □ No	□ Other:	□ Yes □ No

WHAT IS YOUR MEDICAL HISTORY?	**Do you have, or have you had, any of the following problems?** (Check which ones)		List any other problems not mentioned.
□ AIDs or Aids related complex	□ Diverticulosis	□ Kidney disease/stones	□ Thyroid disease □ Hypothyroid
□ Anemia	□ Epilepsy/Seizures	□ Leukemia	□ Hyperthyroid □ Hyperparathyroid
□ Asthma	□ Glaucoma	□ Mental health problems	□ Inflammatory bowel disease
□ Bleeding disorder	□ Gout	□ Pancreatitis	□ Inflammatory Eye disease (Iritis, uveitis, episcleritis)
□ Cataracts	□ Headaches	□ Phlebitis	□ Positive TB Skin test □ Tuberculosis (TB)
□ Cancer :	□ Heart disease/heart attacks	□ Pleurisy/fluid on lungs	□ Ulcers Bleeding? □ Yes □ No
□ Congestive heart failure:	□ Hepatitis/Jaundice	□ Pneumonia	□ Venereal disease
□ Diabetes	□ High blood pressure	□ Strokes □ Psoriasis	□ Rheumatic fever
Please list any other medical problems not mentioned:			□ Long COVID

WHAT IS YOUR SURGICAL HISTORY? **Have you had any of kind of surgery, in or out of a hospital**? □ **Yes** □ **No** If yes, describe the surgeries below. Surgery includes plastic/cosmetic surgery or procedures (breast implants, collagen injections, lifts, tucks, etc.)

What operation was performed:	When:	Who performed the operation:	Where?

Have you ever had any

Broken bones or fractures?	□ Yes □ No	When?	Which bone?
Other major injuries?	□ Yes □ No	When?	Describe
Transfusions?	□ Yes □ No	When?	Where?

WHAT IS YOUR FAMILY MEDICAL HISTORY?

Father □ Alive/age	Current health		□ Dead/ age died	Cause of death
Mother □ Alive/age	Current health		□ Dead/ age died	Cause of death
Number of Brothers	Number alive	Number dead	Age died	Cause of death
Number of Sisters	Number alive	Number dead	Age died	Cause of death
Number of Children	Number alive	Number dead	Age died	Cause of death
Ages of Living Children				
Major illnesses of Children				

Has any blood relative (parent, grandparent, aunt, uncle, sibling, child, etc.) had any of the following conditions?

Check if yes	Relation	Check if yes	Relation
□ Ankylosing spondylitis		□ Cancer:	
□ Arthritis (type unknown)		□ Cancer:	
□ Childhood arthritis		□ Cancer:	
□ Colitis		□ Congestive heart failure	
□ Fibromyalgia		□ Diabetes	
□ Gout		□ Epilepsy	
□ Lupus or SLE		□ Heart problems	
□ Osteoarthritis		□ High blood pressure	
□ Osteoporosis		□ Kidney disease/stones	
□ Psoriasis		□ Leukemia	
□ Rheumatoid arthritis		□ Rheumatic fever	
□ Other arthritis condition		□ Stroke	
□ Alcoholism		□ Thyroid problems	
□ Asthma		□ Tuberculosis (TB)	
□ Bleeding tendency		□ Ulcer	
		□ Inflammatory Eye disease	

Please list any other family medical problems not mentioned.

SOCIAL HISTORY

Occupation/ Major Activities: □ _____ Employment situation: □ Full-time □ Part-time □ Unemployed □ Retired □ Disabled
□ Homemaker □ Student Time spent weekly working, doing housework and/or going to school _____

Education: Years of school attended: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Marital Status: Check all that apply □ Never married □ Married □ Cohabiting □ Separated □ Divorced □ Widowed
Spouse/significant other: □ Alive/age □ Dead/age died Current health/cause of death _____

Home Situation: Live in: □ House □ Apartment □ Condo □ Yes □ No Stairs to climb, If yes, how many ____ Primary Language: _____
Live: □ Alone □ With parents (#) _____ □ Spouse □ Children (#) _____ □ Siblings (#) _____ □ Others (#) _____
Do you do most of the: Housework ? □ Yes □ No Shopping? □ Yes □ No Yardwork? □ Yes □ No

Exercise/Hobbies: Do you □ Jog □ Swim □ Walk - how long, how briskly? _____ Hobbies? _____

Travel: □ Yes □ No Have you travelled in the last few years? If so, where:

Hike/Camp: □ Yes □ No Have you hiked/camped in the last few years? If so, where:
□ Yes □ No Have you had any insect/tick bites? If yes, when

Caffeine: □ Yes □ No Do you drink coffee or tea? If yes, how many cups per day: ___
□ Yes □ No Do you drink soda with caffeine? If yes, how many cans per day ___

Smoking: □ Yes □ No Do you smoke cigarettes? Age started ___ If yes, how many packs per day? ___
□ Yes □ No Did you smoke cigarettes? Age started ___ If yes, how many packs per day? ___ Age you stopped? ___
□ Yes □ No Do you smoke anything else besides cigarettes? If yes, what?

Alcohol: □ Yes □ No Do you drink alcohol? If yes: □ Beer □ Wine □ Hard liquor Drinks per day? ___
□ Yes □ No Has anyone ever told you To drink less alcohol?
□ Yes □ No Do you use drugs for recreational purposes?
□ Yes □ No Have you ever injected drugs?

Driving: □ No □ Yes Are you able to drive?

Sleep: □ No □ Yes Do you get enough sleep at night? How many pillows do you use? ___
□ No □ Yes Do you feel rested when you wake up? What time do you: Go to bed? ___
□ No □ Yes Is it easy for you to: Go to sleep? What time do you: Go to sleep? ___
□ No □ Yes Is it easy for you to: Stay asleep? What time do you:: Wake up in the morning? ___
□ No □ Yes Is it easy for you to: Obtain restful sleep? What time do you: Get out of bed? ___

MEDICATIONS

Drug Allergies

Do you have any allergies to medications? □ Yes □ No If yes, to what:

Type of reactions

CURRENT MEDICATIONS: What Medications are you taking now?

List ALL medications you are taking, prescription and non prescription. Non prescription items include aspirin, ibuprofen, naproxen, vitamins, laxatives, supplements (calicum, iron, etc.), herbs, etc. Indicate the dose (strength of the pill and number of pills per day), whether it is helpful, and whether you have had any bad reactions or discomfort from the medicine (we sometime call these problems "side effects).

Name of Medication	Dose	Pills daily	Start Date	Reason using	Does it help	Reactions to the medication

PAST ARTHRITIS MEDICATIONS: The following is a list of many arthritis and other medications. Please CIRCLE each medication you have taken

Pain / NSAIDS	**NSAIDs...**	**Corticosteroids**	**"Anti-Rheumatic Drugs..."**	**Biologics-BRM, Cont..**	**Muscle Relaxants**	**Anti-depressant**
	Ansaid					
Advil (Ibuprofen)	Duexis	Cortisone	Olumiant	Rituxin	Flexeril	Celexa
Aspirin	Celebrex	Medrol	Otezla	Simponi	Norflex	Cymbalta
Tylenol	Clinoril	Prednisone	Imuran	Stelara	Parafon forte	Desaryl
Tylenol with Codeine	Daypro	Prednisolone	Methotrexate pills	Taltz	Robaxin	Effexor
	Dolobid	**Gout Medicines**	Methotrexate	Tremfya	Soma	Elavil
	Feldene	Allopurinol	shots	Skyrizi	Skelaxin	Lexapro
		Benemid				
Vicodin	Indocin	Colcrys	Penicillamine	**Stomach/Anti-ulcers**	Zanaflex	Paxil
Hydrocodone	Lodine	Colchicine	Plaquenil	Antacids	**Osteoporosis**	Pristiq
Norco	Meclomen		Rasuvo	Aciphex	Actonel	Prozac
	Mobic	Krystexxa	Rinvoq	Axid	Atelvia	Serzone
Disalcid	Motrin	Mitigare	Xeljanz	Carafate	Boniva	Sinequan
	Nalfon	Uloric	**Biologics-BRMs**	Cytotec	Calcitonin	Savella
Lyrica	Naproxyn		Actemra	Dexilant	Didronel	Tofranil
Neurontin	Orudis	**"Anti-Rheumatic Drugs"**	Cimzia	Nexium	Evenity	Zoloft
Nucynta	Oruvail	Arava	Cosentyx	Pepcid	Evista	**Sleep**
Toradol	Relafen	Azulfidine	Enbrel	Prevacid	Forteo	Ambien
	Tolectin	Cyclosporine	Humira	Prilosec	Fosamax	Lunesta
Ultram	Voltaren	Cytoxan	Kevzara	Protonix	Miacalcin	Sonata
Ultracet	Vimovo	Gold shots or	Kineret		Prolia	Rozerem
		Gold Pills(Ridaura)			Reclast	
Zostrix		Cellcept	Orencia	Tagamet	Teriparatide	Dalmane
			Remicade	Zantac	Tymlos	Halcion
			→			Restoril

For each medication circled above (and any other arthritis medication not listed), please do the following

Name of Medication	**Dose: Strength of Pill**	**Pills per day**	**Start Date**	**Stop Date**	**Did it help? 1. No 2. A little 3. A lot**	**Reason stopped 1. Did not work 2. Stopped working 3. Did not need 4. Side effects**	**Reactions to the medication 1. Stomach upset 2. Bleeding ulcer 3. Kidney 4. Liver 5. Lung 6. Skin 7 Other**

REVIEW OF SYSTEMS: Check which symptoms apply to you; please complete any blanks.

GENERAL

Fatigue
- Chronic □ Yes □ No
- Recent □ Yes □ No

Weakness
- Generalized □ Yes □ No
- Local □ Yes □ No
- *Where?* _____

Fever □ Yes □ No
- High? □ Yes □ No
- *How often?* _____

Recent weight change □ Yes □ No
- *How much?* _____ □ *Gain* □ *Loss*

Loss of appetite □ Yes □ No

Thirst □ Yes □ No

SKIN

Bruise easily □ Yes □ No

Rash □ Yes □ No

Redness □ Yes □ No

Hives □ Yes □ No

Tightness □ Yes □ No

Hair loss □ Yes □ No

Dry □ Yes □ No

Nodules/Bumps □ Yes □ No

Sensitive or allergic to sunlight □ Yes □ No

Hands/feet change color in cold □ Yes □ No

Increased pigmentation □ Yes □ No

Decreased pigmentation □ Yes □ No

Ulcerations (sores) □ Yes □ No

EARS

Ringing in ears □ Yes □ No

Hearing loss/impaired □ Yes □ No

EYES

Painful □ Yes □ No

Red □ Yes □ No

Dry □ Yes □ No

Loss/impaired vision □ Yes □ No

Double or blurred vision □ Yes □ No

Feels like something in eye □ Yes □ No

NOSE

Nosebleeds □ Yes □ No

Loss/impairment of smell □ Yes □ No

Dry □ Yes □ No

MOUTH

Sore tongue □ Yes □ No

Gums bleed □ Yes □ No

Sores in mouth □ Yes □ No

Loss/impairment of taste □ Yes □ No

Dry □ Yes □ No

Yeast in mouth □ Yes □ No

THROAT

Frequent sore throats □ Yes □ No

Hoarse □ Yes □ No

Hard to swallow □ Yes □ No

NECK

Swollen glands □ Yes □ No

Tender glands □ Yes □ No

HEART and LUNGS

Chest pain □ Yes □ No

Heart murmur □ Yes □ No

Irregular heart beat □ Yes □ No

Sudden changes in heart beat □ Yes □ No

Shortness of breath □ Yes □ No

Wheezing □ Yes □ No

Difficulty breathing at night □ Yes □ No

Cough up blood □ Yes □ No

Coughing □ Yes □ No

Swollen legs, ankles or feet □ Yes □ No

High blood pressure □ Yes □ No

Night sweats □ Yes □ No

STOMACH and INTESTINES

Nausea □ Yes □ No

Heartburn □ Yes □ No

Indigestion □ Yes □ No

Stomach pain relieved by food, milk or antacids. □ Yes □ No

Blood in stools □ Yes □ No

Black stools □ Yes □ No

Vomit blood or coffee ground-like material □ Yes □ No

Jaundice/yellow skin □ Yes □ No

Constipation □ Yes □ No

Diarrhea □ Yes □ No

KIDNEY/URINE/BLADDER/GENITALS

Have difficulty trying to urinate □ Yes □ No

Pain or burning when urinating □ Yes □ No

Blood in urine □ Yes □ No

Pus in urine □ Yes □ No

Urine is cloudy or "smoky" □ Yes □ No

Discharge from penis or □ Yes □ No

Have to urinate frequently □ Yes □ No

Must get up at night to urinate □ Yes □ No

Vaginal dryness □ Yes □ No

Genital rash/ulcers □ Yes □ No

Herpes □ Yes □ No

Prostate problems □ Yes □ No

Sexual activities limited □ Yes □ No
- By disease □ Yes □ No
- Other reasons □ Yes □ No

BLOOD

Anemia □ Yes □ No

Bleeding tendency □ Yes □ No

NERVOUS SYSTEM

Headaches/Where
- Front of head □ Yes □ No
- Back of head □ Yes □ No

Dizziness/When
- All the time □ Yes □ No
- When changes positions □ Yes □ No

Fainting □ Yes □ No

Loss of consciousness □ Yes □ No
- *When?* _____

Memory loss – can't remember
- Recent activity □ Yes □ No
- Old events □ Yes □ No

Muscle spasm
- Generalized □ Yes □ No
- Localized □ Yes □ No
- *Where?* _____

Sensitivity or pain due to cold
- In hands □ Yes □ No
- In feet □ Yes □ No

Numbness/tingling
- Hands □ Yes □ No
- Arms □ Yes □ No
- Feet □ Yes □ No
- Legs □ Yes □ No

Coordination problems □ Yes □ No

Do you have difficulty
- Relaxing □ Yes □ No
- Concentrating □ Yes □ No
- Deciding things □ Yes □ No

Are you: Nervous □ Yes □ No
- Depressed □ Yes □ No
- Worried a lot □ Yes □ No
- Losing your temper □ Yes □ No
- Anxious □ Yes □ No

MENSTRUAL HISTORY **[ ] N/A, male**

Age periods began _____ Lasting how long _____ Days apart _____
Age periods ended _____
Month/year of: Last Menstrual period _____
Month/year of: Last bleeding of any kind _____

□ Yes □ No Do you consider yourself postmenopausal. If yes, was it
□ Natural menopause □ Surgical menopause (hysterectomy)
□ Yes □ No Were one or more ovaries removed?

□ Yes □ No Are/were your periods regular
Were your periods infrequent or absent:

□ Yes □ No For one or more years

□ Yes □ No Because of athletic participation (running, gymnastics, diving, etc.)

□ Yes □ No Have you ever used contraception. If yes, describe:
Current: _____
Past: _____

□ Yes □ No Have you ever taken estrogen therapy (ERT/HRT)?
If yes, date started: _____Date stopped:_____
If no, why not? _____
Current ERT/HRT:_____
List all previous ERT/HRT: _____
_____
If you stopped, ERT/HRT, why?
_____

OSTEOPOROSIS PROFILE QUESTIONS

Sex/Race: □ Female □ Male □ White □ Asian □ Hispanic □ Black □ Other :
Age/Ancestry: Age _____ □ N Europe □ Scotch □ Irish □ English
Height Changes: Maximum Height: _____ Height today: _____
Weight Changes: Weight at 20: _____ At 50 _____ Today _____

□ Yes □ No Have you been told you have osteoporosis?

□ Yes □ No Have you been told your x-ray shows low bone mass?

□ Yes □ No Have you ever had a bone density study? If yes, was it:
□ Spine □ Hip □ Wrist □ Ankle
When: _____ Where: _____

□ Yes □ No Have you ever had a CT scan of your spine or hip

□ Yes □ No Have you broken any bones? Which ones:
□ Spine □ Hip □ Wrist □ Ankle
□ Rib □ Toe □ Other _____

□ Yes □ No Have you taken any of the medicines below? Which ones:
□ Fosamax □ Actonel □ Evista □ ERT/HRT
□ Calcitonin □ Fluoride □ Didronel

□ Yes □ No Do you have a family history of osteoporosis?
□ Mother □ Daughter □ Sister □ Grandmother
□ Father □ Son □ Brother □ Grandfather

□ Yes □ No Did any family members with osteoporosis have a fracture?
□ Mother □ Daughter □ Sister □ Grandmother
□ Father □ Son □ Brother □ Grandfather

□ Yes □ No Do you have scoliosis (curvature of the spine)?

□ Yes □ No Do you have any of these physical characteristics?
□ Petite/small build (8 or less dress/36 or less jacket)
□ Light hair, fair skin, freckles when young

□ Yes □ No Are you/have you been inactive, immobile or confined indoors?

□ Yes □ No Do you have/did you have an eating disorder?
□ Anorexia □ Bulimia □ Other

□ Yes □ No Do you/did you smoke more than 1 pack /cigarettes day?

□ Yes □ No Do you/did you drink 2 or more alcohol beverages a day?

□ Yes □ No Do you/did you drink 2 or more caffeine beverages a day?

□ Yes □ No Was your dairy product use limited for any reason?
□ Allergic □ Caused cramps or stomach upset
□ Consumed 2 or less milk products day

□ Yes □ No Do you/did you taken any of the following medications:
□ Prednisone/Medrol □ Dilantin
□ Chemotherapy □ Heparin/Coumadin
□ Methotrexate □ Lupron
□ Thyroid supplements □ Lithium

□ Yes □ No Do you/did you have any of the following health problems:
□ Gastric surgery □ Asthma
□ Epilepsy □ Breast Cancer
□ Rheumatoid arthritis □ GI/Bowel disease
□ Liver problems □ Prostate cancer
□ Thyroid supplements □ Infertility
□ Kidney diseases □ Malabsorption syndrome
□ Juvenile diabetes □ Transplant recipient

□ No □ Yes Did you breast feed any children?

□ No □ Yes Do you take calcium supplements?

□ No □ Yes Do you take a multivitamin or Vitamin D supplement?

□ No □ Yes Are you physically active?
□ Jog □ Walk frequently □ Swim □ Other

Robin K. Dore, M.D. Inc

12791 Newport Ave., Suite 201, Tustin CA 92780 ~ Tel: 714 505 5500 Fax: 714 505 3381

Authorization For Use or Disclosure of Protected Health Information

I hereby authorize **X**_____ (the "Health Care Provider") to use and disclose health information concerning the following patient:

X_____ as follows:

Health information to be used or disclosed: Any and all health information other than psychotherapy notes may be disclosed, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically written below:

[optional]_____

Disclosure may be by means such as, but not limited to, providing copies of the records containing patient's health information, faxing such records and/or by allowing inspection and/or copying of such records

This health information may be disclosed to:

Robin K. Dore, M.D and/or Robin K. Dore, M.D., Inc.
12791 Newport Ave., Suite 201, Tustin CA 92780 Tel: 714 505 5500 Fax: 714 505 3381

who may use this information only for the following purposes written below – **examples**, medical care, insurance, at the request of the individual, etc.

X_____

I understand that I may revoke this authorization at any time by notifying the Health Care Provider in writing. My revocation will not affect actions taken by the Health Care Provider in reliance on this authorization prior to receipt of my revocation.

I understand that after the Health Care Provider discloses this health information to another person or entity, federal law (the HIPAA Privacy Rule) may no longer protect the privacy of this health information and it might be further disclosed.

Effect of Refusal to Sign Authorization: I understand that my (or the patient's named above if I am not the patient) health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now. It expires on the following date: _____ if not revoked sooner. If no date is written in this blank, this authorization expires **1 year** after the date this authorization is signed.

I understand that I have the right to receive a copy of this authorization.

Signed: **X**_____ Print Name: **X**_____

Dated: **X**_____ Relationship if not Patient: _____