Christine Chai, M.D.

901 Dover Drive, Suite 214
Newport Beach, CA 92660

Patient Information: **Birth Date:** _____ **Age:** _____

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ Zip Code: _____

Telephone#: _____ Cell Phone#: _____ Social Security #: _____

Drivers License #: _____ Marital Status: M / D / S / W

What telephone number may we leave private detailed messages _____

Referred By:

Employment Information:

Occupation: _____ Employed by: _____

Address: _____ City: _____ Zip Code: _____

Telephone #: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ City: _____ Zip Code: _____

Telephone #: _____

Insurance Information:

Primary Insurance Carrier:

Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Birthdate: _____ Social Security #: _____

Relationship to Patient: _____ Insured's Employer: _____

Insured's Group #: _____ ID#: _____ Policy #: _____

Effective Dates of Policy: From: _____ To: _____ Phone # _____

Secondary Insurance Carrier:

Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Birthdate: _____ Social Security #: _____

Relationship to Patient: _____ Insured's Employer: _____

Insured's Group #: _____ ID#: _____ Policy #: _____

Effective Dates of Policy: From: _____ To: _____ Phone # _____

Assignment of Benefits/Financial Agreement:

I hereby give authorization for payment of insurance benefits to be made directly to Christine Chai, M.D. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance company. (Medicare patients are subject to Medicare's policies and regulations.) I hereby authorize Christine Chai, M.D. to release all information necessary to my insurance company(s) to secure the payment of benefits. I further agree that a photocoy of this agreement shall be as valid as the original.

Signature: _____ **Date:** _____

Revised 09292010

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F):_____ **Today's Date(MM/DD/YY):**_____ **Health Care Provider:**_____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☒Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE/ENDOMETRIAL CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐Y ☐N Are you of Ashkenazi Jewish descent?

☐Y ☐N Are you concerned about your personal and/or family history of cancer?

☐Y ☐N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome* *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome* *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

HEALTH INTAKE FORM

Name_____ **Today's Date**_____

What brings you here today? _____

Primary Physician_____

CURRENT MEDICATIONS none ☐

_____ _____
_____ _____
_____ _____

Do you take a multi-vitamin ☐ Omega 3/fish oil ☐ Aspirin ☐
Calcium ☐ Vitamin D ☐ Other vitamins or herbs ☐

ARE YOU ALLERGIC TO: No known drug allergy ☐

Penicillin ☐ Sulfa ☐ Codeine ☐
Latex ☐ Iodine ☐ Other ☐ _____

SURGICAL HISTORY:
Please indicate year when done

D and C _____
Cesarean Section _____
Tubal Ligation _____
Laparoscopy _____
Hysterectomy _____
Cryosurgery/laser _____

Appendectomy _____
Gall Bladder _____
Blood Transfusion _____
Breast surgery/ _____
or biopsies
Other surgeries _____

MEDICAL HISTORY (check if yes)

No known medical problems ☐

Heart disease ☐
Stroke ☐
Blood clots in legs/lungs ☐
High cholesterol ☐
High blood pressure ☐
Asthma ☐
Lung/TB ☐
Diabetes ☐
Thyroid issues ☐
Arthritis ☐
Osteopenia/Osteoporosis ☐
Cancer (type) _____ ☐

Autoimmune (lupus, MS,etc) ☐
Bleeding disorder/anemia ☐
Kidney disease/stones ☐
Bowel disease/IBS ☐
GERD ☐
Gallstones ☐
Hepatitis ☐
Neurologic Issues ☐
Migraine headaches ☐
Depression/Anxiety ☐
Alcohol/Drug abuse ☐

FAMILY HEALTH HISTORY (check if anyone in your family has ever had the following)

Heart disease/attack	☐	Thyroid disease	☐
Stroke	☐	Osteoporosis	☐
Blood clots in legs/lungs	☐	Alzheimer's/dementia	☐
High cholesterol	☐	Depression/schizophrenia	☐
Diabetes	☐	Alcoholism	☐

FAMILY CANCER HISTORY

Please check if there is a family history of any of the following cancers. If yes, then indicate family relationship (i.e. sister or paternal grandmother (PGM)) and age at diagnosis in the appropriate column.

Breast cancer	☐	_____
Ovarian cancer	☐	_____
Male breast cancer	☐	_____
Are you of Ashkenazi Jewish descent?	☐	_____
Uterine (endometrial) cancer	☐	_____
Colorectal cancer	☐	_____
Stomach, kidney/urinary tract, brain, or small bowel cancer	☐	_____
10 or more cumulative colon polyps	☐	_____
Melanoma	☐	_____
Pancreatic cancer	☐	_____
Other cancer	☐	_____

PREGNANCY HISTORY

Number of pregnancies _____ # of living children _____ # of deliveries _____
# of miscarriages _____ # of ectopics _____ # of abortions _____

GYNECOLOGIC HISTORY

Date of last Pap smear _____ Normal? Yes ☐ No ☐
Date of last mammogram _____ Normal?: Yes ☐ No ☐
Location of last mammogram Hoag ☐ Newport Imaging Center ☐
Newport Diagnostic Center ☐ Other ☐ _____

Have you ever had any of the following (check yes if applicable)

Abnormal Pap smear	☐	Current pain with intercourse	☐
Genital herpes	☐	Current vaginal discharge or odor	☐
Genital warts/HPV	☐	Frequent yeast or bacterial infections	☐
Chlamydia	☐	Frequent urinary infections	☐
Gonorrhea	☐	DES exposure	☐

Breast lump ☐ Nipple discharge ☐ Breast pain ☐

What is your current method of contraception? Birth control pill/ring ☐ IUD ☐
Depo Provera ☐ Vasectomy ☐ Tubal ligation ☐ Condoms ☐ Rhythm ☐ No need ☐

MENSTRUAL HISTORY (if menstruating)

Age at 1st period _____ Date of 1st day of last period _____
Number of days between periods (1st day to 1st day of next cycle) _____
How many days do your periods usually last? _____
Please check if you answer yes to any of the questions below
Is heavy flow a problem? ☐ Do you bleed between periods? ☐
Do you have PMS? ☐ Do you bleed with intercourse? ☐
Do you have bad cramps? ☐
If so, what do you take for cramps? _____

MIDLIFE/MENOPAUSE HISTORY (if menopausal or perimenopausal)

Please check if you answer yes to any of the symptoms below

Hot flashes	☐	Low sex drive	☐
Night sweats	☐	Loss of urine	☐
Trouble sleeping	☐	Urinary frequency	☐
Mood changes	☐	Vaginal dryness	☐

Colonoscopy	Date_____	Result_____
DEXA scan	Date _____	Result _____
Cholesterol screening	Date _____	Result _____
Skin cancer screening	Date _____	Result _____

HEALTH HABITS

Tobacco use Never ☐ Quit ☐ Date _____
Current smoker ☐ Packs per day _____ # of years _____
Alcohol intake Never ☐ Yes ☐ Drinks per week _____
Caffeine intake None ☐
Coffee ☐ _____ cups per day
Tea ☐ _____ cups per day
Soda ☐ _____ cans per day
Recreational drug use Never ☐ Previously ☐ Currently ☐ IV drug use ☐
Do you exercise regularly? Yes ☐ No ☐ How many times a week? _____
Do you eat a balanced diet? Yes ☐ No ☐
Are you currently dieting? Yes ☐ No ☐
Any history of eating disorder? Yes ☐ No ☐
Have you encountered physical or sexual abuse? ☐

REVIEW OF BODY SYSTEMS
Please check all that are applicable to your CURRENT reason for visit

Fever	☐	Chest pain	☐	Constipation	☐
Chills	☐	Palpitations	☐	Bloating	☐
Fatigue	☐	Shortness of breath	☐	Easy bruising	☐
Weight gain/loss	☐	Abdominal pain	☐	Headache	☐

CHRISTINE CHAI, MD

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that Dr. Chai 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 (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit Dr. Chai 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 Dr. Chai to complete my annual exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that Dr. Chai will want to know how my condition progresses after I leave the office. Returning to see Dr. Chai on time gives her the chance to check my condition and my response to treatment. During a follow-up appointment, she 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 Dr. Chai 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.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that Dr. Chai's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from the office within 10 business days, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, Dr. Chai may make certain recommendations based on what she 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 her recommendations so that she may fully inform me of any risks associated with my decision to delay or refuse treatment.

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.

Patient Signature	Date	Physician Signature

Acknowledgement of Receipt of Notice of Privacy Practices

Christine Chai, MD
901 Dover Drive, Suite 214
Newport Beach, CA 92660

Privacy Officer: Hilda Ceja 949-631-1333
Effective Date: October 1, 2010

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above medical practice. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

Signed:_____ Date_____

Print Name: _____