Arthur Po-Fei Chou, M.D.

120 W Hellman Ave # 204, Monterey Park, CA 91754
Tel: (626) 768-7373 • Fax (626) 478-3373

For Staff Use Only	
Height	Influenza Vaccine
Weight	Pneumonia Vaccine
Vitals	

Patient Information / *Información del paciente*

(***Please Print / Por favor imprimir***)

Name / *Nombre*: _____
First Name / *Primer nombre* Middle Name / *Segundo nombre* Last Name / *Apellido*

Date of Birth / *Fecha de nacimiento*: _____/_____/_____ **Age / *Edad***: _____
MM / *Mes* DD / *Fecha* YYYY / *Año*

Gender / *Género*:

☐ Male / *Masculino* ☐ Female / *Femenina* (Pregnant? / *¿Embarazada?*: Yes / *Sí* / No)

☐ Other / *Otros* ☐ Decline to Specify / *Rechazar especificar*

Social Security Number / *Número de seguridad social*: _____

Address / *Dirección*: _____

City / *Ciudad*: _____

State / *Estado*: _____ Zip Code / *Código postal*: _____

Home Phone # / *Teléfono de casa #*: _____ - _____ - _____ , _____ - _____ - _____

Cell Phone # / *Teléfono móvil #*: _____ - _____ - _____ , _____ - _____ - _____

Email Address / *Dirección de correo electrónico*: _____

Occupation / *Ocupación*: _____

Employer Name / *Nombre del empleador*: _____

Work Phone # / *Teléfono del trabajo #*: _____ - _____ - _____, ext. _____

Employer Address / *Dirección del empleado*: _____

City / *Ciudad*: _____

State / *Estado*: _____ Zip Code / *Código postal*: _____

Emergency Contact / *Contacto de emergencia*: _____

Relationship / *Relación*: _____

Contact # / *Contacto #*: _____ - _____ - _____ , _____ - _____ - _____

Do you authorize us to discuss your medical condition with the person listed above? / *¿Nos autoriza a discutir su condición médica con la persona mencionada anteriormente?* ☐ Yes / *Sí* ☐ No

Referring Doctor / *Médico de referencia*: _____

Clinic Phone # / *Teléfono de la clínica #*: _____ - _____ - _____

Primary Care Doctor / *Médico de atención primaria*: _____

Clinic Phone # / *Teléfono de la clínica #*: _____ - _____ - _____

Reason for today's visit / *Motivo de la visita de hoy*:

_____

_____

_____

_____

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Race / *Raza*:
☐ American Indian or Alaska Native / *Indio americano o nativo de Alaska*
☐ Asian / *Asiático*
☐ Black or African America / *Negro o afroamericano*
☐ Native Hawaiian or Other Pacific Islander / *Nativo hawaiano u otro isleño del Pacífico*
☐ White / *Blanco*
☐ Other Race (Please Specify) / *Otra Raza (Especifique)*: _____
☐ Decline to Specify / *Rechazar especificar*

Ethnicity / *Etnicidad*:
☐ Hispanic or Latino / *Hispano o latino*
☐ Not Hispanic or Latino / *No hispano o latino*
☐ Decline to Specify / *Rechazar especificar*

Preferred Language (Multiple Choice) / *Idioma preferido (Opción múltiple)*:
☐ Cantonese / *Cantonés* ☐ English / *Inglés*
☐ Mandarin / *Mandarín* ☐ Spanish / *Español*
☐ Other (Please Specify) / *Otro (por favor especifique)*: _____

Handedness / *Mano*:
☐ Left-Handed / *Mano izquierda* ☐ Right-Handed / *Mano derecha*

Medical History (Please Mark) / *Historial Médico (Marque por favor)*:
☐ None / *Ninguno*
☐ Asthma / *Asma*
☐ Bleeding Tendency / *Tendencia a sangrar*
☐ Cancer (Please Specify) / *Cáncer (Por favor especifique)*: _____
☐ Cranial Aneurysm / *Aneurisma craneal*
☐ Diabetes / *Diabetes*
☐ Gastritis / *Gastritis*
☐ Heart Disease / *Enfermedad del corazón*
☐ Hepatitis / Liver Disease / *Hepatitis / Enfermedad Hepática*
☐ Hereditary Defects / *Defectos Hereditarios*
☐ HIV / AIDS / *VIH / SIDA*
☐ Hypertension / High Blood Pressure / *Hipertensión / Presión Arterial Alta*
☐ Osteoarthritis / *Osteoartritis*
☐ Renal / Kidney Disease / *Enfermedades del riñón* → dialysis?/ *¿diálisis?* ☐ Yes / *Sí* ☐ No
☐ Rheumatoid Disease/ Gout / *Enfermedad reumatoide / gota*
☐ Seizures / *Convulsiones*
☐ Stroke / *Derrame cerebral*
☐ Tuberculosis (TB) / *Tuberculosis (TB)*
☐ Other (Please Specify) / *Otro (por favor especifique)*: _____

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Surgical History / *Historia de la cirugía*:
☐ Yes / *Sí* ☐ None / *Ninguno*
If Yes, please list any surgeries, hospitalizations, or traumatic injuries you have had, including the year and name of the hospital(s).
En caso afirmativo, indique las cirugías, hospitalizaciones o lesiones traumáticas que haya tenido, incluido el año y el nombre del hospital.

_____

_____

Allergies / *Alergias*:
☐ None / *Ninguno*
☐ Anesthetic / *Anestésico*: _____
☐ Codeine / *Codeína*: _____
☐ Penicillin / *Penicilina*: _____
☐ Sulfa / *Sulfa*: _____
☐ Latex / *Látex* ☐ Rubber / *Caucho* ☐ Tape / *Cinta*
☐ Food Allergies / *Alergias a los alimentos*: _____
☐ Other Drug Allergies / *Otras alergias a medicamentos* _____

Are you taking medicine? / *¿Está tomando medicamentos?*:
☐ Yes / *Sí* ☐ No
If Yes, please list all current medications (prescriptions, over-the-counter, herbal, etc.)
En caso afirmativo, enumere todos los medicamentos actuales (recetados, de venta libre, a base de hierbas, etc.)

Pharmacy / *Farmacia*: _____
Phone # / *Número de teléfono #*: _____ - _____ - _____
Address / *Dirección*: _____

Medication Name and Dose *Nombre y dosis del medicamento*	**Frequency** *Frecuencia*	**Uses** *Usos para*	**Prescribing Doctor** *Doctor que prescribe*

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Family History (Please Mark) / *Historia Familiar (Marque por favor)*:

☐ None / *Ninguno*
☐ Family History Unknown / *Historia familiar desconocida*
☐ Asthma / *Asma*
☐ Bleeding Tendency / *Tendencia a sangrar*
☐ Cancer (Please Specify) / *Cáncer (Por favor especifique)*: _____
☐ Cranial Aneurysm / *Aneurisma craneal*
☐ Diabetes / *Diabetes*
☐ Gastritis / *Gastritis*
☐ Heart Disease / *Enfermedad del corazón*
☐ Hepatitis / Liver Disease / *Hepatitis / Enfermedad Hepática*
☐ Hereditary Defects / *Defectos Hereditarios*
☐ HIV / AIDS / *VIH / SIDA*
☐ Hypertension / High Blood Pressure / *Hipertensión / Presión Arterial Alta*
☐ Osteoarthritis / *Osteoartritis*
☐ Renal / Kidney Disease / *Enfermedades del riñón*
☐ Rheumatoid Disease/ Gout / *Enfermedad reumatoide / gota*
☐ Seizures / *Convulsiones*
☐ Stroke / *Derrame cerebral*
☐ Tuberculosis (TB) / *Tuberculosis (TB)*
☐ Other (Please Specify) / *Otro (por favor especifique)*: _____

Height / *Altura*: _____ Feet / *Pies* _____ Inches / *Pulgadas*

Weight / *Peso*: _____ Pounds / *Libras*

Have you had any of the following vaccines this year?
¿Ha recibido alguna de las siguientes vacunas este año?

Flu Shot / *Vacuna contra la gripe*
☐ Yes / *Sí*
☐ No

Pneumonia Vaccine / *Vacuna contra la neumonía*
☐ Yes / *Sí*
☐ No

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Social History / ***Historia Social***

Ability to Work / *Capacidad para trabajar*

- ☐ Not limited / *No limitado*
- ☐ Moderately limited / *Moderadamente limitada*
- ☐ Severely limited / *Severamente limitada*

Are you retired? / *¿Estás jubilado actualmente?*

- ☐ Yes / *Sí*
- ☐ No

Disability / *Discapacidad*

- ☐ Not disabled / *No discapacitado*
- ☐ Disabled / *Deshabilitado*
- ☐ Applying for disability / *Solicitud de discapacidad*

Marital Status / *Estado Civil*

- ☐ Single / *Soltero*
- ☐ Married / *Casado*
- ☐ Divorced / *Divorciado*
- ☐ Widowed / *Viudo*

Alcohol Use / *Consumo de alcohol*

- ☐ Never / *Nunca*
- ☐ 1-5 weekly / *1-5 semanales*
- ☐ > 2 daily / *> 2 diarios*
- ☐ Quit / *Salir*
  - ↳ When did you quit? / *¿Cuándo dejaste?* _____

Tobacco Use / *El consumo de tabaco*

- ☐ Never / *Nunca*
- ☐ Occasional / *Ocasional*
  - ↳ How many packs a day? / *¿Cuántos paquetes al día?* _____
- ☐ Quit / Salir
  - ↳ When did you quit? / *¿Cuándo dejaste?* _____

Other Substances / *Otras sustancias*

- ☐ Type/Name of the drug / *Tipo/Nombre de la droga* _____
- ☐ Never / *Nunca*
- ☐ Occasional / *Ocasional*
- ☐ Frequent / *Frecuente*

*The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

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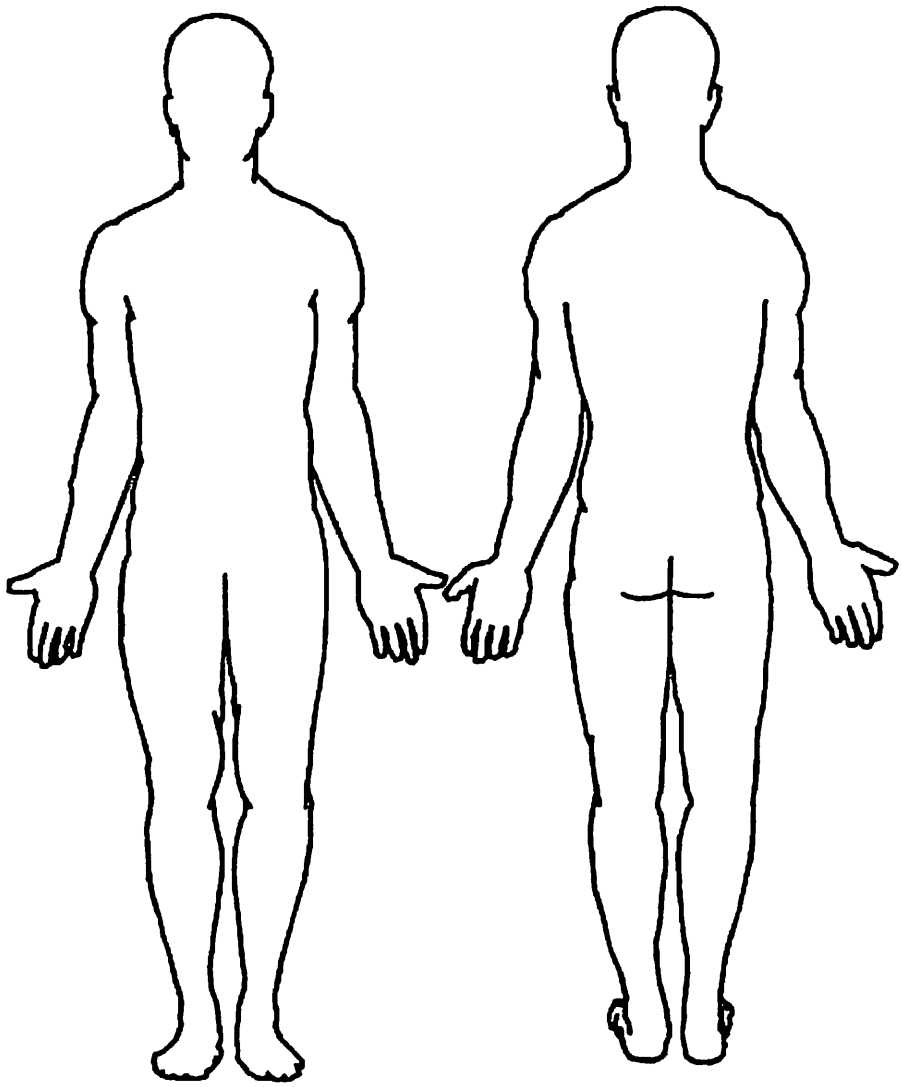
Please draw where your pain is:
Por favor, dibuje DÓNDE está su dolor:

Front / *Delantero* Back / *Atrás*



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When did your pain start? / *¿Cuándo comenzó su dolor?* _____

How often do you have a pain? / *¿Con qué frecuencia tiene dolor?* _____

Your pain is / *Tu dolor es*:

☐ Sharp / *Afilado*
☐ Shooting / *Disparo*
☐ Tingling / *Hormigueo*
☐ Numb / *Entumecido*
☐ Heavy / *Pesado*
☐ Other (Please Specify) / *Otro (por favor especifique)*: _____

How bad is your pain on a scale of 0 to 10?
¿Qué tan fuerte es su dolor en una escala de 0 a 10?
0 (No Pain / *Sin dolor*) 1 2 3 4 5 6 7 8 9 10 (Worst / *Peor dolor*)

Has your pain gotten better over time? / *¿Su dolor ha mejorado con el tiempo?*
☐ Better / *Mejor* ☐ Same / *Igual* ☐ Worse / *Peor*

Do you have pain when you first wake up?
¿Tiene dolor cuando se despierta por primera vez? ☐ Yes / *Sí* ☐ No

Does your pain change with these positions?
¿Cambia tu dolor con estas posiciones?

Laying Down / *Acostado*:
↳☐ Better / *Mejor* ☐ Same / *Igual* ☐ Worse / *Peor*
Sitting / *Sentado*:
↳☐ Better / *Mejor* ☐ Same / *Igual* ☐ Worse / *Peor*
Standing / *En pie*:
↳☐ Better / *Mejor* ☐ Same / *Igual* ☐ Worse / *Peor*
Walking / *Caminando*:
↳☐ Better / *Mejor* ☐ Same / *Igual* ☐ Worse / *Peor*
When bending forward and/or backward / *Al inclinarse hacia delante y/o hacia atrás*:
↳☐ Better / *Mejor* ☐ Same / *Igual* ☐ Worse / *Peor*

How does your pain affect your daily life?
¿Cómo afecta su dolor en su vida diaria?

_____
_____
_____
_____
_____

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What types of studies and treatments have you had?
¿Qué tipos de estudios y tratamientos ha tenido?
☐ None / *Ninguno*
☐ X-Rays / *Rayos X*
☐ CAT Scan / *Análisis de gato*
☐ MRI / MRA / *Resonancia magnética / Angiografía por resonancia magnética*
☐ EMG / NCV
☐ Physical Therapy / *Terapia física*
☐ Injections / *Inyecciones*
☐ Other (Please Specify) / *Otro (por favor especifique)*: _____

If you have tried physical therapy, was your last session within the last 6 months?
¿Si ha probado la fisioterapia, fue su última sesión en los últimos 6 meses?
☐ Yes / *Sí*
☐ No

↳**Did physical therapy provide significant relief?**
¿La fisioterapia proporcionó un alivio significativo?
☐ Yes / *Sí*
☐ No

Have you tried injections for the pain?
¿Has probado inyecciones para el dolor?
☐ Yes / *Sí*
☐ No

↳ **Any significant relief?**
¿Algun alivio significativo?
☐ Yes / *Sí*
☐ No

Are you interested in considering surgery?
¿Estás interesado en considerar cirugía?
☐ Yes / *Sí*
☐ No

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services tendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All Claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physician's or Authorized Representative's Signature (Date)

Arthur P. Chou, M.D.

Print or Stamp Name of Physician, Medical Group or Association Name

By _____ _____

Patient's or Patient Representative's Signature (Date)

By _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.