PRINT CLEAR FORM

UCLA Health

Name:

DOB:

MRN:

PATIENT INFORMATION SHEET

Department of Orthopaedic Surgery

PLEASE PRINT

1. Were you referred to this office? No Yes

   If yes, who referred you? _____

2. Chief Complaint (what problem brings you in today?)

   _____

   _____

3. History of your Main Complaint

   _____

   _____

4. Past Medical History (Any medical problems?:

   _____

   _____

5. Past Surgical History (Any surgery in the past?)

   _____

   _____

6. Current Medications: Allergies:

   _____ _____

   _____ _____

7. Social History:

   Do you smoke? No Yes If yes, how much per day? _____

   Do you drink alcohol? No Yes If yes, how much per day? _____

   Occupation: _____

   Living Situation: _____

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8. Family History of Medical Problems (If yes, explain):

Father: ☐ No ☐ Yes _____

Mother: ☐ No ☐ Yes _____

Grandparents: ☐ No ☐ Yes _____

Siblings: ☐ No ☐ Yes _____

9. Any Medical Problems in the following areas?

	No	Yes	If yes, explain:
Constitutional symptoms: fever, weight loss, fatigue	☐	☐	
GI problems	☐	☐	
Eyes	☐	☐	
Ears, nose, throat	☐	☐	
Heart, circulation	☐	☐	
Bladder	☐	☐	
Breathing, lungs, shortness of breath	☐	☐	
Other miscellaneous problems	☐	☐	
Skin	☐	☐	
Nerves, coordination, neurological	☐	☐	
Psychological	☐	☐	
Endocrine	☐	☐	
Blood, lymphatics	☐	☐	
Immune problems	☐	☐	
Menstrual problems	☐	☐	

Patient or Representative Signature _____

Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ID # _____

Date _____ Time _____

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MRN:

EMAIL CONSENT FORM

- **UCLA Health Systems**
- **Santa Monica UCLA Medical Center and Orthopedic Hospital**
- **Stewart and Lynda Resnick Neuropsychiatric Hospital**

You and your Health care provider have agreed to correspond using electronic mail (E–mail). This form provides guidelines for the intended use of this type of communication, and documents for your consent.

IN A MEDICAL EMERGENCY, DO NOT USE E–MAIL. CALL 911

E–Mail Use:	Generally, e–mail correspondence should be between the provider and an adult patient 18 years or older, or parent or legal guardian of a minor.
Privacy and Confidentiality:	Unless your provider tells you specifically that the e–mail will be conducted via a secure server, consider e–mail like a postcard that can be viewed by unintended persons. In addition, the content of the e–mail may be monitored by the hospital to ensure appropriate use. Discuss with your provider who will process your e–mail messages during business hours, vacations or illness. All e–mails regarding your care will be included in your medical record.
Creating a Message:	On the “Subject” line, include the general topic of the message, for example, Prescription or Appointment or Advice. In the body of the message, include your name and your identification number (Medical Record Number) or your date of birth.
Content of The Message:	E–mail should be used only for non–sensitive and non–urgent issues. Types of information appropriate for e–mail include: • Questions about prescriptions • Routine follow–up inquiries • Appointment scheduling • Reporting of self–monitoring measurements, such as blood pressure and glucose determinations. According to the California law, your provider may not communicate any lab results unless your e–mail correspondence is conducted through a secure server. Additionally, e–mail must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.

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Response Time:	Discuss with your provider the expected time in which to receive a response. If the expected time is exceeded, call your provider at the phone number below.
Ending E–Mail Relationship:	Either you or your provider may request via e–mail or letter to discontinue using e–mail as a means of communication.
Disclaimer:	**UCLA Health System, Santa Monica UCLA Medical Center and Orthopedic Hospital and Stewart and Lynda Resnick Neuropsychiatric Hospital are not responsible for e–mail messages that are lost due to technical failure during composition, transmission and/or storage.**

I have read and understand the information above, and have had any and all questions answered to my satisfaction. I agree to the guidelines for e–mail communication.

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Patient E–mail address (please print): _____

Provider Name: David R. McAllister, MD Telephone Number (310) 206-5250

Provider E–mail address (please print): DrMcAllisterOffice@mednet.ucla.edu