Arrival: **Harbor-UCLA Medical Foundation Inc. – Diagnostic & Wellness Center #33-0003558** FEMALE

Last Name/First/MI: **(Please print clearly)**				Date of Service:		**OFFICE USE ONLY** ☐ **Heart** ☐ **Abdomen** ☐ **Body** ☐ **Lung** ☐ **Pelvis** ☐ **Colon** ☐ **Carotid** ☐ **BMD** ☐ **CIMT** ☐ _____
Height:	Weight:	BMI:	Waist:	Date of Birth:	Age:	

Referring Physician

Have you had this test before? ☐ Yes ☐ No If yes, date _____ Score _____

Medical History (respond to all that apply): ☐ **I may be Pregnant**

Race: ☐ White/Caucasian ☐ African-American ☐ Hispanic/Latino ☐ American Indian ☐ Native Hawaiian/Pacific ☐ Indian (Asian) ☐ Asian_____ ☐Other_____

Yes	No	Question?
☐	☐	Have you had chest pain recently?
☐	☐	Are you a diabetic? Type_____ Medication(s):
☐	☐	Have high cholesterol? Medication(s):
☐	☐	Have high blood pressure? Medication(s):
☐	☐	Do you have any family history of heart disease? Family member:

Lifestyle: ☐ Sedentary ☐ Active ☐ Stressful

Diet type: ☐Regular, Mixed ☐ Low Fat ☐ Low Salt ☐Vegetarian ☐High Protein ☐Other_____

Tobacco Use: ☐ Never ☐ Current ☐ Past-quit date: _____

Yes	No	Question?	Date?
☐	☐	Have you had a stroke?	
☐	☐	Have you had a heart attack?	
☐	☐	Have you had heart angioplasty?	
☐	☐	Do you have stents? # of Stents_____	
☐	☐	Have you had bypass surgery? # of Grafts_____	
☐	☐	Do you have any kidney disease?	
☐	☐	Any known lung disease? ☐ Emphysema ☐ Asthma ☐ COPD ☐ Other _____	
☐	☐	Are you post-menopausal? Date: If Yes, ☐ Hysterectomy ☐Oophorectomy ☐Hormone replacement therapy	
☐	☐	Do you Exercise?	
☐	☐	Do you consume alcohol? How much: _____ ounces per week	

Any other Important Medical History:

For Staff Use Only

INTERPRETATION

☐ NEGATIVE ☐ LESS THAN ☐ AVERAGE
☐ GREATER THAN ☐ MUCH GREATER THAN

Comments:_____

_____

By: ☐ MB ☐RO ☐JC

Initial: _____

Scanned _____ Consult _____Scored _____

	# OF	Score
LM	_____	_____
LAD	_____	_____
CX	_____	_____
RCA	_____	_____
Total	_____	_____

ADMINISTRATION

Charge _____

RESEARCH STUDY _____

☐PT FX ☐PT MAIL DATE: _____

☐MD FX ☐MD MAIL DATE: _____

☐IMAGE/CD MAILED: _____

Harbor-UCLA / Medical Foundation Inc. – Diagnostic & Wellness Center
Notice of Privacy Practices
Effective: 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.

Our privacy practices:

♥ We maintain physical and electronic records and process safeguards to restrict unauthorized access to the health information of our clients, both past and present. These include secure office buildings, controlled computer network systems, and passwords.

♥ Other people that we do business with must also protect your health information if we must give it to them.

What do we mean by "health information?" Health information is information about you that is used to identify you, including your birth date, address, and social security number. This information is also anything about your past, present, or future medical condition, evaluation and treatment of any such condition, and related health services.

How we receive information about you: We receive information about our clients in several ways. Information is given from referring physicians, clinics, labs, and hospitals that may provide your medical care. Information is also given from employers, or benefit sponsor or associations, consumer or medical reporting agencies, or other third parties. Finally, from our affiliates and contracted medical groups.

How we may use and share information about you: We may share health information with doctors or hospitals to help them provide medical care for you. We may use information in your health record to judge the quality of health care you receive. We may also use this information in regulatory or other audits, in legal investigations, in our fraud and abuse program, when checking your eligibility, enrollment, and when checking the quality of the services we provide. We may use your health information to contact you with your appointment reminder, information about treatment alternatives or other health-related benefits and services that may be of service or interest to you.

Other uses of your health information: You or your doctor, hospital, and other health care providers may appeal or review the way we managed your care. Your health information may be used so that we can make decision about these appeals and grievances. We may share your health information with the federal government when it is checking on how we are meeting privacy rules. Sometimes a court of law will order us to give your health information to another person. We may also share your health information if otherwise required by law.

What are your privacy rights? You have the right to ask us not to share your health information in the ways described above. We may not be able to agree to your request. You have a right to ask us to contact you if you believe it is necessary for your safety. You or your personal representative has the right to get a copy of your health information. You have the right to ask that information in your record be amended if you believe it is not complete or correct. If we do not make the changes you ask for, you may ask that we review the decision.

How you can contact us to use your privacy rights: Diagnostic & Wellness Center – Medical Foundation Inc., 1124 W. Carson Street, Torrance, CA 90502, (310) 222-3844

Do you have a concern about your privacy?

If you believe that we have not protected your privacy and want to file a complaint with us, you may call us at the address and phone number shown below. You may also contact the US Department of Health Services by sending your concern to them in writing at the following location:

Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights
Attention: Regional Manager, 50 United Nations Plaza, Room 322, San Francisco, CA 94102
For additional information, call (800) 368-1019
Or
U.S. Office for Civil Rights at (866) OCR-PRIV (866) 627-7748, or (866) 788-4989 (TTY)

You will not be penalized for filing a complaint. You may also use your privacy rights without fear of being punished. Changes to notice of privacy practices: Diagnostic & Wellness Center/Medical Foundation Inc. must obey the notice currently in effect. We have the right to change these privacy practices.

_____ _____ _____
Printed Name Signature Date

☐ Signature refused/ Reason: _____