



Medical Excellence Clinic

Wen L. Guo, MD, Ph.D

Internal Medicine | Integrative Medicine | Functional Medicine | Acupuncture
郭雯 医师 (内科/针灸)

Registration Form (Please Print)

Today's Date: _____ PCP: _____

Patient Information

Patient's Last Name:		First:	Middle:	___Mr. ___Miss ___Mrs. ___Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this your legal name?	If not, what is your legal name?	Former Name:			Birth date: / /	Age: /
Street Address:		Social Security #:			Home Phone:	
PO Box:	City:	State:	Zip Code:	Cell Phone:		
Occupation:	Employer:				Employer Phone:	
Chose clinic because/Referred to clinic by (Please circle):			Dr.	Insurance Plan	Hospital	
Family	Friend	Website		Magazine	Newspaper	
Other family members seen here:				Email address:		

Insurance Information

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (If different):
Is this person a patient here?	Patient's relationship to subscriber: ___Self ___Spouse ___Child ___Other	

In case of emergency

Name of local friend or relative (Not living at the same address):	Relationship to patient:	Home Phone:	Work/Cell Phone:
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The above information is true to the best of my knowledge. I authorize my Insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Medical Excellence Clinic or insurance company to relaease any information required to process my claims.

Patient/Guardian's signature

Date

Medical Excellence Clinic Appointment Cancellation Policy

Dear Patients:

If you cannot make appointment for any reason, kindly give us 24 hours notice by making a phone call (702) 895 -9968 or text us (407 579 3220) . Fail to give such notice will subject \$20 no show fee.

Thank you for understanding

Medical Excellence Clinic

I have read and understand above statement and agree to bind by the policy

Patient Signature _____

Date _____



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郭雯 医师 (内科/针灸)

Name _____

Date _____

To provide the best possible healthcare, I need to completely understand your physical, mental and emotional condition. By providing me with this information I will be able to understand and assist you with your health needs and goals. Please print your answers to each question completely as possible and either mark or leave blank any questions you are unsure of.

Current Concern (Please rank by priority)

Example	Onset	Frequency	Severity
Headache	June 1999	4 times a week	Mild/Moderate
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

What are your goals for this visit?

- _____
- _____
- _____
- _____

Please list any hospitalizations and surgeries you have had:

Surgery/Hospitalization	Year
_____	_____
_____	_____
_____	_____

Family History: Please mark if you or family members have experienced the following (Please indicate which family member if: self, mother, father, brother, etc):

Cancer: _____	Diabetes: _____
Heart Disease: _____	Blood Pressure: _____
Mental Illness: _____	Lung Condition: _____
Allergies: _____	Depression: _____
Bipolar: _____	Infertility: _____

Social History:

What is your occupation and do you enjoy it? _____

Please circle one: Single Married Divorced Separated Widow/ed

How many children do you have? _____ How old? _____

What are the major stresses in your life? _____

What do you do to relax/recreate/socialize/cope with stress? _____

What are your hobbies and interests? _____

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When are you happiest, what gives you joy? _____

What is/are your support system(s) {friends? church? Relatives? Pets?} _____

Review of Systems: Self Medical History: Please list issues you may have regarding each category or leave blank if not applicable:

Skin: _____

Head/Neck: _____

Respiratory: _____

Cardiovascular: _____

Gastrointestinal: _____

Urinary: _____

Female Reproductive: _____

Male Reproductive: _____

Do you have any sexual worries or concerns? Yes ___ No ___ If yes, please describe _____

Musculoskeletal: _____

Neurological: _____

Psychiatric: _____

Do you exercise? Yes ___ No ___ How often? _____

What type of exercise? _____

Awake Rested? Yes ___ No ___ Sleep well? Yes ___ No ___ Average hrs/night of sleep? _____

Use tobacco? Never ___ Yes ___ Smoked from age ___ to ___ _____ packs a day

Alcohol? Never ___ Estimated drinks per day _____

Use illegal drugs? Never ___ Type & Frequency _____

Have you ever been treated for substance abuse of any kind? Yes ___ No ___

Nutritional History: Recall of Dietary Intake:

Do you eat three meals a day? Yes _____ No _____

Please list all food and drinks you have consumed in the previous 24 hours, include meals, snacks, beverages and condiments:

Breakfast: _____

Lunch: _____

Snacks: _____

Dinner: _____

Is this a typical day? Yes ___ No ___ If not, why not? Please describe _____

Are there any types or group of foods you crave or eat a lot? _____

Are there any types or groups of foods you dislike or rarely eat? _____

How much beverages do you consume daily? Coffee ___ Tea ___ Soda ___ Water ___

What type of oil do you use? Vegetable ___ Olive ___ Canola ___

What kind of spread do you use? Butter ___ Margarine ___ Other _____

Patient Printed Name _____ Date: _____

Patient Signature: _____

