Nathan Newman, MD
American Advanced Medical Corporation

PATIENT INFORMATION

Date:

Name: Mr. Ms. Mrs. _____
Last First Middle

Sex: Male Female ☐ **Marital Status:** Single Married Widowed Separated Divorced

Address: _____ Apt # _____

City: _____ **State:** _____ **Zip code:** _____

Date of Birth: Month Day Year **Age:**___
Patient's Drivers License #: **State:** **Patient's Social Security #**:
_____ _____

Home Phone: ( ) _____ **Cell Phone:** ( ) _____

E-mail Address:_____ **Business Phone:** (_____)_____**ext:** _____

Patient Employer: _____ **Patient Occupation:** _____

Address: _____

Spouse's Name: _____
Name of guardian or insured (If other than patient) **Relationship to patient:**

_____ _____

IN CASE OF EMERGENCY, NOTIFY: _____
Last First Relationship

_____ (_____)_____ (_____)_____
E-mail Day Phone Evening Phone

Allergies: _____

Reason for visit: _____

How did you hear about us? _____

FOR OFFICE USE ONLY			
Insurance:	Medisoft input date: _____	Initials:	Info Updated:
Loyalty number	Contact List input date:	Initials:	Info Updated:
Max per day:	Deductable:	Co-pay:	

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PATIENT HEALH QUESTIONNAIRE

Your medical history is very important, as it helps to alert us of any potential problems that might interfere with your surgery. Please take the time to fill this form out completely and accurately. The information will be kept confidential.

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS?

	Yes	No		Yes	No
Asthma			Do you smoke?		
Diabetes			Do you use recreational drugs?		
High blood pressure			Problems with anesthesia		
Heart problems			Has any BLOOD RELATIVE of yours ever had		
Rheumatic fever			problems with ANESTHESIA?		
Chest pain			Unsatisfactory medical care		
Shortness of breath			Complications after surgery		
Tuberculosis			Do you wish correction of past surgical result?		
Severe headaches					
Seizures			Have you ever had a colonoscopy?		
Recurrent severe dizziness			Heartburn		
Eye or vision problems			Varicose leg veins		
Recurrent abdominal problems			Problems with your feet		
Blood in bowel movements			Problems with your wrists		
Kidney or bladder problems					
Blood in urine			Sinus problems		
Problems with bones or joints			Trouble breathing		
Abnormal lump or node			Snoring		
Emotional problems			Trouble sleeping		
Psychiatric treatment			Do you feel unrested in the morning?		
Venereal disease					
Hepatitis A B C			Pregnant or trying to become pregnant		
HIV Positive			Breast feeding		
Cancer			Heavy periods/Irregular menstrual cycle		
Chronic skin condition			Have you ever had a mammogram?		
Bleeding disorder, easy bruising			When was your last PAP smear?		

Other medical conditions:

Medications & Supplements (herbal,vitamins, hormones,etc.)

THIS INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

Patient Signature

Date