NEW LIFE MEDICAL

Patient Information and Medical History Questionnaire

Please complete the following questionnaire and bring it with you to your appointment. It is important to complete this form as accurately as possible, to assist us in providing you with the highest quality medical care.

PATIENT INFORMATION

Patient Name:		◯ Male ◯ Female	
Race/Ethnicity: ◯ Caucasian/White ◯ Black/African American ◯ Hispanic ◯ Asian ◯ American Indian/Alaskan Native ◯ Native Hawaiian/Other Pacific Islander ◯ Asian Pacific American ◯ Other: ◯ Decline to state			
Language:			
Date of Birth:	Soc Sec No:	Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed	
Mailing Address:		Apt No:	
City:		State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
E-Mail		Can we contact you using this email? ◯ Yes ◯ No	

RESPONSIBLE PARTY

Name of Person Responsible:		Relationship to Patient:	
Date of Birth:	Phone:	Soc Sec No:	
Mailing Address:		Apt:	
City:		State:	Zip
Employer/School Name:		Phone:	
Employer Address:			
City:		State:	Zip:

EMERGENCY CONTACT(S)

Name:	Relationship to Patient:
Home Phone:	Work Phone:
Name:	Relationship to Patient:
Home Phone:	Work Phone:

Nirav Naik, MD FACS & Cyrus Moon, MD
4817 Centennial Plaza Way, Suite C, Bakersfield, CA 93312
P: (661) 447-4559, F: (661) 447-4565

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EMPLOYMENT INFORMATION

Patient Employment Status: ◯ Working Fulltime ◯ Working Part-Time ◯ Unemployed ◯ Student ◯ Retired – Date of Retirement:			
Employer/School Name:			
Patient Occupation:		Employer Phone:	
Employer Address:			
City:		State:	Zip:

PRIMARY INSURANCE INFORMATION

Insurance Plan:		Phone:	
Policy No:	Group No:	Claims Phone:	
Name of Insured:	Patient's relationship to Insured:		
Insured's Mailing Address:		Apt:	
City:		State:	Zip:
Insured's Date of Birth:	Insured's Soc Sec No:		

AUTHORIZATION TO BILL INSURANCE

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S).

I AUTHORIZE AND DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO NEW LIFE WEIGHT LOSS AND LIFESTYLE SOLUTIONS AND/OR OTHER CARE PROVIDERS WHO RENDER SERVICES AT THIS OFFICE.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY REQUIRE AN AUTHORIZATION NUMBER, PRECERTIFICATION AND/OR REFERRAL. WITHOUT THIS DOCUMENTATION, I UNDERSTAND THAT MY INSURANCE CARRIER MAY DENY BENEFITS. IF MY INSURANCE CARRIER DENIES PAYMENT FOR SERVICES RENDERED BY NEW LIFE MEDICAL AND/OR TO THE PHYSICIAN(S) AND/OR OTHER CARE PROVIDERS WHO RENDERED SERVICE(S), I AGREE TO BE RESPONSIBLE FOR PAYMENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE SUCH AS, BUT NOT LIMITED TO, DEDUCTIBLES AND CO-INSURANCE AMOUNT(S).

Signature:	Date:

Signature of the Person Responsible for Payment:

NEW LIFE MEDICAL

Patient Name: _____

Date of Birth: _____

Have you seen Dr. Naik or Dr. Moon in the past? ◯ **Yes** ◯ **No**

If yes - when, and for what reason? _____

Who referred you to us? _____ **Who is your primary MD?** _____

REASON FOR VISIT

Please describe in your own words the reason for this visit: _____

When did this problem begin? _____

Have you had this problem previously in the past? Y N If yes, when was the first time? _____

Is your problem currently getting better or worse? _____

What makes your problem better/worse? _____

Have you had any prior treatment for this problem? _____

PAST MEDICAL HISTORY

Diabetes?	**Y**	**N**	**How long?** _____		**On insulin?**	**Y**	**N**
Glucose intolerance/pre-diabetes?	**Y**	**N**					
High Blood Pressure?	**Y**	**N**	**How long?** _____		**Heart Failure?**	**Y**	**N**
History of heart attack?	**Y**	**N**	**When?** _____		**Heart stent or surgery?**	**Y**	**N**
Atrial fibrillation (irregular heartbeat)?	**Y**	**N**	**When?** _____		**Pacemaker/Defibrillator?**	**Y**	**N**
History of stroke?	**Y**	**N**	**When?** _____		**History of mini-strokes?**	**Y**	**N**
Asthma/Emphysema/COPD?	**Y**	**N**	**On oxygen at home?**	**Y**	**N**		
Sleep Apnea?	**Y**	**N**	**Are you using a CPAP or BiPAP?**	**Y**	**N**		
Heartburn? Hiatal hernia?	**Y**	**N**	**On any medications for heartburn?**	**Y**	**N**		
High Cholesterol?	**Y**	**N**					
Hepatitis B or C?	**Y**	**N**	**Cirrhosis, or other liver problems?**	**Y**	**N**		
Varicose (spider) veins?	**Y**	**N**	**Any leg discomfort/swelling?**	**Y**	**N**		
History of blood clot (legs, lungs)?	**Y**	**N**	**On any blood thinners, or have had IVC filter?**			**Y**	**N**
Back pain? Y N Joint pain?	**Y**	**N**	**On any pain medications?**	**Y**	**N**		
History of Gout?	**Y**	**N**	**On medications currently?**	**Y**	**N**		
Low thyroid? Y N	**High thyroid?**		**Y**	**N**			

Any other medical problems? _____

_____

_____

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PRIOR SURGERIES

PROCEDURE	DATE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

MEDICATIONS

(Please list dosage, how often, and what it is for; or please attach a list if available)

1.	**8.**
2.	**9.**
3.	**10.**
4.	**11.**
5.	**12.**
6.	**13.**
7.	**14.**

ALLERGIES

Medication:	Reaction:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Latex: ◯ Yes ◯ No	Tape: ◯ Yes ◯ No	Iodine: ◯ Yes ◯ No
Other:		

Use the back of this form if additional space is needed.

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REVIEW OF SYSTEMS

Please mark all that apply. If you do not understand a term, please let us know so that we may assist you.

General ◯ No Symptoms

◯	Fever	◯	Fatigue
◯	Chills	◯	Recent involuntary weight loss
◯	Night Sweats	◯	Loss of appetite

Neuro-Psycho-Social ◯ No Symptoms

◯	Severe headaches	◯	Alcohol or Drug Abuse
◯	Dizziness	◯	Obsessive-compulsive disorder
◯	Fainting	◯	Bipolar disorder
◯	Convulsions or seizures	◯	Eating disorder (bulimia, etc)
◯	Psychiatric illness	◯	Tremors
◯	Depression or Anxiety Disorder	◯	Numbness in arms or legs
◯	Suicide attempts	◯	Weakness in arms or legs
◯	History of Emotional or Physical Abuse	◯	Pseudotumor Cerebri

Eyes, Nose, Ears, Throat ◯ No Symptoms

◯	Seeing double	◯	Sinus pain
◯	Blurry vision	◯	Recurrent sore throat
◯	Eye pain	◯	Hoarseness or weak voice
◯	Ringing in the ears	◯	Swollen glands in the neck

Respiratory System ◯ No Symptoms

◯	Asthma (Wheezing)	◯	Shortness of breath
◯	Chronic cough	◯	Pneumonia
◯	Coughing up blood	◯	Tuberculosis
◯	Snoring/gasping at night (waking you)	◯	Valley Fever (coccidioidomycosis)
◯	Periods of not breathing while sleeping (Sleep Apnea)		
Using:	◯ CPAP ◯ BIPAP ◯ Home Oxygen		

Cardiovascular ◯ No Symptoms

◯	Chest Pain or discomfort	◯	Leg pains below the knee
◯	Heart Murmur	◯	Skin problems on legs or feet
◯	Prior blood transfusions	◯	Varicose veins
◯	Bleeding or bruising problems	◯	Leg swelling/ulcers
◯	Blood clot problems	◯	Compression stockings

Endocrine/Metabolic ◯ No Symptoms

◯	Iron Deficiency Anemia	◯	Thyroid problems
◯	Vitamin Deficiency	◯	Cannot stand heat or cold
◯	Abnormal fasting glucose	◯	Excessive thirst
◯	Lactose Intolerance	◯	Hair changes

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Gastrointestinal ◯ No Symptoms

◯	Heartburn (GERD)	◯	Red blood in stool
◯	Difficulty swallowing	◯	Black or tarry stools
◯	Nausea or vomiting	◯	Excessive gas
◯	Abdominal pain	◯	Trouble holding gas
◯	Stomach ulcers	◯	Trouble restraining stool
◯	Diarrhea	◯	Colon or rectal problems
◯	Constipation	◯	Yellow skin or eyes (jaundice)
◯	Irritable bowel syndrome	◯	Abnormal liver tests
◯	Change in bowel habits	◯	History of pancreatitis

Genitourinary (Urinary) ◯ No Symptoms

◯	Burning with urination	◯	Urinary stream is smaller
◯	Pain with urination	◯	Increased urinary frequency
◯	Loss of bladder control	◯	Blood in urine
◯	With sudden movements such as Coughing, sneezing, or laughing	◯	Kidney failure
		◯	Kidney Stones
◯	Difficulty starting to urinate	◯	Getting up at night to urinate? How many times _____

Musculoskeletal ◯ No Symptoms

◯	Joint Pain	◯	Problems walking
◯	Back Pain	◯	Using a walker or a cane
◯	Bone Pain	◯	Unable to walk 200 ft (1/2 block)
◯	Muscles decreasing in size	◯	Using a wheelchair
◯	Arthritis (formal diagnosis)	◯	Difficulty getting up without help

Skin ◯ No Symptoms

◯	Dry Skin	◯	Prior skin infections
◯	Itching	◯	MRSA – Methicillin-Resistant Staphylococcus Aureus Infection
◯	Current Skin Rash		
◯	Extra Skin (Hanging)	◯	VRE – Vancomycin-Resistant Enterococcus Infection
◯	with difficulty grooming		
◯	with difficulty walking	◯	History of Skin Surgery

Men's Health ◯ No Symptoms

◯	Prostate problems	◯	Erectile dysfunction On medication? Y N

Women's Health ◯ No Symptoms

◯	No periods for more than 6 months	Date of last PAP test:
◯	Menopause	Date of last mammogram:
◯	Irregular cycles	Number of pregnancies:
◯	Polycystic ovarian syndrome	Number of live births:
◯	Did you breast feed your children?	

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FAMILY HISTORY

Diabetes	High Blood Pressure	Obesity
Heart Disease	Cancer	Gallstones
Strokes	Difficulty with Anesthesia	Adopted (Don't Know)
Other:		

SOCIAL HISTORY

Occupation:		Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed	
Number of Children and Ages:			
Smoking:	◯ Yes ◯ Quit ◯ Never	How much?	Date Quit:
Alcohol:	◯ Yes ◯ Quit ◯ Never	How much?	Date Quit:
Drugs:	◯ Yes ◯ Quit ◯ Never	Type?	Date Quit:
Caffeine:	◯ Yes ◯ No	Type?	Date Quit:

Notification to Patients

- **As of January 1, 2016, there will be a $35 fee for missed appointments and cancelations made within less than 24 hrs.**
- **As of January 1, 2016, there will be a $150 fee for surgery cancelations made within less than 24 hrs.**
- **If I choose to have robotic surgery, I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE; THIS MAY ALSO INCLUDE A $500 SURCHARGE FOR THE INCREASED COST OF ROBOTIC USE.**

Photographs

I consent to and authorize New Life Medical and the attending physician and/or medical staff to take photographs of me before, during and after treatment; I agree that these photographs become property of the doctor, to be used as he deems fit. This may include publication in a journal, article, social media, or book. My permission is granted to show these photographs to any other physician, patient or persons. My personal information will not be shared. Initials____

Consent for information Exchange

◯ I agree to allow New Life Medical to obtain External Prescription History provided by Surescripts. This information will help our office better manage your care and prescriptions. Initials____

◯ I agree to allow New Life Medical to share clinical and demographic information electronically with other healthcare providers. (such as hospitals, your primary care physician and other physician as needed to facilitate your medical care. Initials____

The information reported on this questionnaire is true to the best of my knowledge.

Print your Name: _____

Signature: _____ Date: _____

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