



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:		<input type="radio"/> Male	<input type="radio"/> Female
I Prefer to Be Called:			
Race/Ethnicity: <input type="radio"/> Caucasian/White <input type="radio"/> Black/African American <input type="radio"/> Hispanic <input type="radio"/> Asian <input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Native Hawaiian/Other Pacific Islander <input type="radio"/> Asian Pacific American <input type="radio"/> Other: <input type="radio"/> Decline to state			
Language:			
Date of Birth:	Soc Sec No:	Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed	
Mailing Address:		Apt No:	
City:	State:	Zip:	
Home Phone:	Work Phone:	Cell Phone:	
E-Mail		Can we contact you using this email? <input type="radio"/> Yes <input type="radio"/> 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
4817 Centennial Plaza Way, Suite C, Bakersfield, CA 93312
P: (661) 447-4559 , F: (661) 447-4565



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Patient Name: _____

Date of Birth: _____

EMPLOYMENT INFORMATION

Patient Employment Status: <input type="radio"/> Working Fulltime <input type="radio"/> Working Part-Time <input type="radio"/> Unemployed <input type="radio"/> Student <input type="radio"/> 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

<p>I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S).</p> <p>I AUTHORIZE AND DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO THIS OFFICE AND/OR OTHER CARE PROVIDERS WHO RENDER SERVICES AT THIS OFFICE.</p> <p>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 THE OFFICE AND/OR TO THE PHYSICIAN(S) AND/OR OTHER CARE PROVIDERS WHO RENDERED SERVICE(S), I AGREE TO BE RESPONSIBLE FOR PAYMENT.</p> <p>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).</p>	
Signature: _____	Date: _____

Signature of the Person Responsible for Payment

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Patient Name: _____

Date of Birth: _____

Have you seen Dr. Naik in the past? Yes No

If yes - when, and for what reason? _____

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

Have any of your family members been seen by Dr. Naik? Yes No

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: <input type="radio"/> Yes <input type="radio"/> No	Tape: <input type="radio"/> Yes <input type="radio"/> No	Iodine: <input type="radio"/> Yes <input type="radio"/> No

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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

<input type="radio"/> Fever	<input type="radio"/> Fatigue
<input type="radio"/> Chills	<input type="radio"/> Recent involuntary weight loss
<input type="radio"/> Night Sweats	<input type="radio"/> Loss of appetite

Neuro-Psycho-Social No Symptoms

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

Eyes, Nose, Ears, Throat No Symptoms

<input type="radio"/> Seeing double	<input type="radio"/> Sinus pain
<input type="radio"/> Blurry vision	<input type="radio"/> Recurrent sore throat
<input type="radio"/> Eye pain	<input type="radio"/> Hoarseness or weak voice
<input type="radio"/> Ringing in the ears	<input type="radio"/> Swollen glands in the neck

Respiratory System No Symptoms

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

Cardiovascular No Symptoms

<input type="radio"/> Chest Pain or discomfort	<input type="radio"/> Leg pains below the knee
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<input type="radio"/> Heart Murmur	<input type="radio"/> Skin problems on legs or feet
<input type="radio"/> Prior blood transfusions	<input type="radio"/> Varicose veins
<input type="radio"/> Bleeding or bruising problems	<input type="radio"/> Leg swelling/ulcers
<input type="radio"/> Blood clot problems	<input type="radio"/> Compression stockings

Endocrine/Metabolic No Symptoms

<input type="radio"/> Iron Deficiency Anemia	<input type="radio"/> Thyroid problems
<input type="radio"/> Vitamin Deficiency	<input type="radio"/> Cannot stand heat or cold
<input type="radio"/> Abnormal fasting glucose	<input type="radio"/> Excessive thirst
<input type="radio"/> Lactose Intolerance	<input type="radio"/> Hair changes

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Gastrointestinal No Symptoms

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

Genitourinary (Urinary) No Symptoms

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

Musculoskeletal No Symptoms

<input type="radio"/> Joint Pain	<input type="radio"/> Problems walking
<input type="radio"/> Back Pain	<input type="radio"/> Using a walker or a cane
<input type="radio"/> Bone Pain	<input type="radio"/> Unable to walk 200 ft. (1/2 block)
<input type="radio"/> Muscles decreasing in size	<input type="radio"/> Using a wheelchair
<input type="radio"/> Arthritis (formal diagnosis)	<input type="radio"/> Difficulty getting up without help

Skin No Symptoms

<input type="radio"/> Dry Skin	<input type="radio"/> Prior skin infections
<input type="radio"/> Itching	<input type="radio"/> MRSA – Methicillin-Resistant

<input type="radio"/> Current Skin Rash	Staphylococcus Aureus Infection
<input type="radio"/> Extra Skin (Hanging)	<input type="radio"/> VRE – Vancomycin-Resistant Enterococcus Infection
<input type="radio"/> with difficulty grooming	<input type="radio"/> History of Skin Surgery
<input type="radio"/> with difficulty walking	
Men's Health <input type="radio"/> No Symptoms	
<input type="radio"/> Prostate problems	<input type="radio"/> Erectile dysfunction on medication? Y N

Women's Health No Symptoms

<input type="radio"/> No periods for more than 6 months	Date of last PAP test:
<input type="radio"/> Menopause	Date of last mammogram:
<input type="radio"/> Irregular cycles	Number of pregnancies:
<input type="radio"/> Polycystic ovarian syndrome	Number of live births:
<input type="radio"/> 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: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed
Number of Children and Ages:	
Smoking: <input type="radio"/> Yes <input type="radio"/> Quit <input type="radio"/> Never	How much? Date Quit:
Alcohol: <input type="radio"/> Yes <input type="radio"/> Quit <input type="radio"/> Never	How much? Date Quit:
Drugs: <input type="radio"/> Yes <input type="radio"/> Quit <input type="radio"/> Never	Type? Date Quit:
Caffeine: <input type="radio"/> Yes <input type="radio"/> No	Type? Date Quit:

Notification to Patients

- As of January 1, 2016, there will be a \$35 fee for missed appointments and cancellations 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 the office and the attending physician and/or medical staff to take photographs
Initials_____

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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.

Consent for information Exchange

I agree to allow the office to obtain External Prescription History provided by Sure scripts. This

Initials_____

information will help our office better manage your care and prescriptions.

I agree to allow the office to share clinical and demographic information electronically with other

Initials_____

healthcare providers. (such as hospitals, your primary care physician and other physician as needed to facilitate your medical care.

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

Print your Name:

Signature: _____ Date: