Name: _____ Date: _____

Referring Doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

ADD
ADHD
Alcoholism
Allergies
Alzheimer's Disease
Anemia _____
Aneurysm
Angina
Anorexia
Anxiety Disorder
Arthritis
Arrhythmia
Aortic aneurysm
Aortic Stenosis
Aortic Insufficiency
Asthma
Atrial fibrillation
Back pain
BPH
Bi-polar disorder
Bladder Cancer
Bleeding Disorder
Blindness
Brain tumors
Breast Cancer
Bronchitis
Cataracts
Cerebrovascular Disease
Cholecystitis
Cholelithiasis
Chronic fatigue syndrome
Chronic liver disease
Chronic lung disease
Chronic renal insufficiency
Chronic Renal Failure
Colitis
Constipation
Colon Cancer
Colon Condition
Congenital Heart Disease
Congenital Heart Failure
Crohn's Disease
Deafness
Deep vein thrombosis
Depression
Diabetes-non ins dependent
Diabetes-insulin dependent
Diabestes-uncontrolled
Diarrhea
Eating Disorder
Ear Infections
Elevated PSA
Emphysema
Enlarged Heart
Epilepsy
Fibrocystic Breast Disease
Fibromyalgia
Gastric Cancer
GERD
Glaucoma
Goiter
Gout
Hay Fever
Heart Attack
Heart Disease
Heart Valve Problem
Heart Murmur
Hemorrhoids
Hepatitis
Herniated Disc
Hiatal Hernia
High Cholesterol
High Blood pressure
Impaired Glucose tol.
Infertility
Irritable Bowel Disease
Inflam. Bowel Disease
Kidney Disease
Kidney Infection
Kidney stones
Infectious Disease
Laryngeal Cancer
Leukemia
Liver Disease
Lung Disease
Lung Cancer
Lymphoma
Malaise
Melanoma
Mental Illness
Migraine
Mitral stenois
Mitral insufficiency
Mitral Valve Prolapse
Mumps
Nervous Breakdown
Obesity
Osteoporosis
Pancreatitis
Pancreatic Cancer
Peptic Ulcer
Phlebitis
Polio
Prostate Cancer
Prostatitis
Pulmonary embolism
Rectal Fissure
Rectal Cancer
Rheumatic Fever
Sexually Trans. Disease
Sickle Cell Anemia
Stroke
Suicide Attempt
Testicular Cancer
Thyroid Disease
Tuberculosis

Other: _____

_____

Name: _____ Date: _____

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

_____ Single _____Married _____Separated _____Divorced _____Widowed _____Life Partner ____Common Law Spouse

Dependants: Please indicate # of each, if you have:

_____Sons _____Daughters _____Stepchildren _____Adopted _____Foster _____Parents _____Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Hobbies: Please circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol Consumption:

_____None _____Yes Occasional/Social # of drinks per day _____

Tobacco per day:

_____None _____Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously stopped, When? _____

Recreational Drugs: _____None If yes, please list: _____

Caffeinated beverages: None Low Moderate Excessive

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods)

_____

_____

Recent Foreign Travel: None Americas _____ Worldwide _____

CURRENT MEDICATIONS - Please list ALL medications you are currently taking including over the counter meds

Drug Name:	**Strength:**	**Directons/How you take it:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Attach list if necessary

Pharmacy Name: _____ **Phone #:** _____

By what method did you choose our practice:

_____Referring Physician _____Friend _____Yellow Pages _____Insurance Company _____Other

Name: _____ Date: _____

SURGICAL HISTORY

Please CIRCLE if you <u>have had</u> any of the following surgeries and date of surgery:

Amputation
Angioplasty
Aortic Aneurysm Repair
Appendectomy
Arthroscopic Surgery
Back Surgery
Bariatric Surgery
Bladder Surgery
Bowel Resection
Brachytherapy
Brain Surgery
Breast Surgery
Biopsy of Prostate
CABG
Carotid Artery Surgery
Carpal Tunnel Surgery (R or L or both)
Cataract Surgery (L or R or both)
Cervical Spine Surgery
Cholecystectomy
Circumcision
Colon Resection
Colonscopy
Corneal Surgery (L or R or both)
Cystoscopy
Cysto-TUR Fulguration
Cyst Removal
Deliverys (Vaginal or C-Section)
Ear Surgey (L or R or both)
EGD
Epididymectomy
ESWL
Eye Surgery (L or R or both)
Facial Surgery
Foot Surgery (L or R or both)
Gastric Surgery
Hand Surgery (L or R or both)
Heart Surgery
Heart Transplant
Hemorrhoidectomy
Herniorrhaphy
Hip Surgery
Hydrocelectomy
Ilioconduit
Ileostomy
Indigo Laser Surgery
Inguinal Herniorrhaphy
Knee Surgery (L or R or both)
Laminectomy
Laparoscopy
Laparatomy
Leg Surgery (L or R or both)
Liver Surgery
Lumpectomy
Lung Surgery
Lymphatic Node Dissection
Lysis Adhesions
Mastectomy
Mastoid Surgery
Meatotomy
Nasal Surgery
Needle Biopsy
Nephrectomy
Nephrolithotomy
Orchiectomy
Pacemaker Insertion
Parathyroidectomy
Penile Implant
PEG
PE Tubes
Pilondial Cyst Incision
Radical Prostatectomy
Renal Transplant
Rotator Cuff Surgery
Septoplasty
Sinus Surgery
Skin Grafting
Spermatocelectomy
Splenectomy
Stomach Surgery
Tonsil Surgery
Thryoid Surgery
TMJ Surgery
TUMT Prostate
TUR Prostate
Umbilical Hernia
Ureteroscopy
Varicocelectomy
Vasectomy
Vein Stripping
Ventral Hernia Repair
VLAPP

Other: _____

_____

FAMILY HISTORY

<u>Please CIRLCE which family member has/had any of the following: (Mother, Father or Siblings)</u>

Arthritis
Bedwetting
Bladder Cancer
Cancer (site unknown)
Crohn's Disease
Depression
Diabetes
Gout
Heart Attack
Hypertension
Kidney Disease
Kidney Stones
Leukemia
Malignant Melanoma
Multiple Sclerosis
Laryngeal Cancer
Pancreatic Cancer
Prostate Cancer
Stroke
Thyroid Disease
Turberculosis

Other: _____

_____

PATIENT REGISTRATION FORM

Patient Last Name: _____ **First Name:** _____

Patient Address: _____

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

Patient Sex: M F **Employed: Y N** **Employer Name:** _____

Home Phone: _____ **Work Phone:** _____ **Ext.** ____

Date of Birth: _____ **Social Security #:** _____

Marital Status: S M W D **Number of Insurance Policies:** _____

Referring Physician: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Address: _____
City, State, Zip: _____ **Phone:** _____
Group Name or #: _____ **Effective Date:** _____ **ID#** _____

Secondary Insurance Name: _____
Address: _____
City, State, Zip: _____ **Phone:** _____
Group Name or #: _____ **Effective Date:** _____ **ID#:** _____

Tertiary Insurance Name: _____
Address: _____
City, State, Zip: _____ **Phone:** _____
Group Name or #: _____ **Effective Date:** _____ **ID#:** _____

Spouse's Name (if applicable): _____ **Spouse's DOB:** _____

Nearest Living Relative /Friend not living with you: _____
Relationship to above: _____ **Phone:** _____

If necessary, did you obtain a referral for this visit? Y N

I authorize the release of medical information necessary to process claims for medical benefits. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health insurance to JACOB ZAMSTEIN, MD, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I realize that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that I am financially responsible for all charges whether or not paid by my insurance including all reasonable costs, expenses, including court and attorney's fees incurred in pursuing collection of such charges.

Signature: _____ **Date:** _____