DOUGLAS J.ZEIGER, M.D.
INFECTIOUS DISEASES
109 East 38th Street
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Name_____Date_____

[Please answer all questions.]

What is the reason for today's visit?

If you are here for travel vaccines- list destinations, date of departure, and duration of the trip.

What medical problems have you had in the past?

Please circle any of the following conditions you have had? Hypertension, Diabetes, Heart Disease, Heart Attacks, Angina, Asthma, Depression, Osteoporosis, Pneumonia, High Cholesterol, HIV Infection, Migraines, Thyroid Disease, Lyme Disease, Cancer, Peptic Ulcer Disease, Cellulitis, Colitis?

List all your surgical procedures with approximate dates:

List all your medications, including dosages, nonprescription and supplements:

List your allergies:

What type of work do you do? Are you exposed to any toxins or chemicals at work?

What is your marital status? How many children? Have you ever been tested for HIV? or Hepatitis C?
Do you smoke cigarettes? How many? If no, did you smoke in the past? When ?
How much exercise do you get? Do you own any firearms? Dietary restrictions?
What is your approximate height and weight? Do you have a history of substance abuse?
How many alcoholic drinks do you have per week? Do you wear seat belts?
Did you have the usual childhood vaccines {tetanus-diphtheria, MMR, polio}?
Have you had any vaccinations in the past ten years {include travel related and influenza}? List vaccines and dates.
Do you have any pets at home? Please list: Have you had a PPD {TB skin test} performed? Result?
Have you traveled outside the US in the past 2 years? Please list:
Have you ever had chickenpox or the chickenpox vaccine?
Did any relative have a history of diabetes, high cholesterol, cancer, dementia, stroke, heart disease, glaucoma, thyroid disease or any other illness? Please list.

Date of last dental visit? Eye doctor-date? Screening colonoscopy-date? EKG-date?

Females only: Pap smear-date? Physician breast exam-date? Mammogram-date?

Males only: PSA test-date? Prostate exam-date?

How high is your cholesterol? When tested? When were any blood tests for any reason last sent?

Do you have a living will? Health care proxy? Advance directives?

Douglas Zeiger, M.D.

PATIENT INFORMATION FORM:

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Last Name: _____ First Name: _____Sex____ Age: _____

Address: _____ City:_____ State: ___Zip:_____Marital Status_____

Home Phone: _____ Business Phone: _____ Cell Number: _____

Date of Birth: _____S S #: _____ email _____Spouse name____

Occupation: _____

_____

Primary Ins. Co. _____ Phone # _____

Policy: _____ Group #: _____

Policy Holder: _____ Relationship to Policy Holder: _____

Deductible Amount: _____ Has this Amount Been Met?: Yes No Co-payment amount_____

_____

Secondary Ins. Co: _____ Phone # _____

Policy: _____ Group #: _____

Policy Holder: _____ Relationship to Policy Holder: _____

_____

Person to Contact in case of Emergency: Name: _____

Phone #:_____ Relationship: _____

_____

Primary Doctor: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

_____

Pharmacy name and location: Phone #

Who referred you? Name: _____ Phone #: _____

Douglas Zeiger, M.D., Name_____ Date _____

Do you have any of the following symptoms (please circle)?

Eyes: floaters, loss of vision, inability to focus, loss of night vision, or pain in the eyes.
Ears, nose, mouth, and throat: pain in the ears, loss of hearing, ringing in the ears,
Loss of smell, running nose, loss of taste, sinus problems, congested nose,
Excessive snoring, painful sores or lumps in the mouth, sore throat, bleeding gums,
Pain on swallowing, lesions on the scalp, facial flushing, neck swelling, swollen glands.

Respiratory: cough, shortness of breath, sputum production, coughing up blood, wheezing, and chest pain.

Cardiovascular: Chest pressure, palpitations, and shortness of breath during exertion, lightheadedness, and leg swelling.

Gastrointestinal: diarrhea, blood in the stool or on toilet paper, black stools, nausea, vomiting, abdominal pain, pain that radiates to the back.

Genitourinary: frequent urination, painful urination, blood in urine, genital sores or ulcers, swelling or pain of testicles.

Musculoskeletal: muscle pain, joint pain, joint swelling, limited motion of any joint, or pain in calf when walking.

Skin: dry skin, skin rash, or itching.

Breast: tenderness, lumps, or discharge.

Neurologic: Numbness in hands and feet, loss of balance, loss of strength, loss of consciousness, seizure, tremor, memory problems, or problems speaking.

Psychiatric: Depression, anxiety, panic-attacks, or unexplained fatigue.

Endocrine: increased thirst, increased urination, abnormal hair growth, darkening skin, and cold or heat intolerance.

Hematologic/Lymphatic: easy bruisability, bleeding gums, enlarged lymph nodes, and extreme fatigue.

General: fevers, night sweats, weight loss, weight gain, loss of appetite, and changes in sexual functions.

How many cigarettes do you smoke?

Are there any changes in your medications, allergies, family history, address, telephone number, or insurance carrier?

Douglas Zeiger, M.D.
109 East 38th Street Name _____ Date_____

I request that payment of authorized commercial insurance or Medicare benefits be made on my behalf to Dr. Douglas Zeiger for any services furnished to me by Dr. Zeiger. I authorize the release of any medical information about me to the Health Care Financing Administration or my commercial insurance carrier needed for processing these claims.

I recognize that I am responsible for any co-payments, deductibles, and noncovered services provided by Dr. Zeiger as determined by my insurance carrier.

Travel vaccinations are frequently noncovered services for many insurance plans and I agree to pay any costs associated with these services if denied by my insurance carrier.

Signature_____Date_____