

Welcome

Alexander G. Nein, M.D., P.C.



Thank you for selecting us!

To help us meet your health care needs, please fill out this form completely in ink (including the other side). If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Date _____

Ms. Mrs. Miss. Mr. Dr.

Name: _____ SSN: _____ - _____ - _____

Address: _____ Work Phone: _____

_____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

E-mail: _____ Fax: _____

Birth Date: ____/____/____

Check Appropriate Boxes: Minor Single Married / Employed Unemployed Retired Student

Patient Employer _____

Business Address _____ City/State _____ Zip _____

Occupation _____

Spouse or Parent Name _____

Spouse Employer _____ Work Phone _____

Emergency Contact _____ Phone _____

Mother's Name _____ Phone _____

How did you hear about Dr. Nein? / Whom may we thank for referring you?

Previous patient: _____

Physician: _____

Other person: _____

Internet: DrNein.com ImplantInfo Am. Soc. of Plastic Surgeons Other: _____

Radio: _____

Yellow pages: Nashville Mfsboro Clarksville Other: _____

Newspaper: Tennessean Nash Woman The Scene Other: _____

Other: _____

What procedure/problem is this consult for?



Patient Medical History

Alexander G. Nein, M.D., P.C.

1. Patient's Name: _____ Height: _____ Weight: _____

2. General Health: Excellent Good Fair Poor

3. Who is your primary care physician? _____ Date of last exam: _____

4. Are you under any medical treatment now? Yes No

5. Have you been hospitalized or had any surgical operation or serious illness within the last five years Yes No

If yes, please explain: _____

6. Are you taking any medication (s) including non-prescription medicine? Yes No

If yes, please explain: _____

7. Do you use tobacco? Yes No Packs per day _____

8. Are you allergic to or have you had any reactions to the following?

Local Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Penicillin or any other antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sulfa Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Barbiturates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sedatives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Iodine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any Metals (nickel, mercury etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex Rubber	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Please list any other drugs or substances to which you are allergic and specify the type of reaction: _____

9. Women Only: a) Are you pregnant or think you may be pregnant? Yes No
 b) Are you nursing? Yes No
 c) Are you taking oral contraceptives? Yes No

10. Do you have or have you had any of the following?

	Yes	No		Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other medical condition: _____