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?

_____

° revised 5-9-13

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	☐ Yes ☐ No	Penicillin or any other antibiotics	☐ Yes ☐ No
Sulfa Drugs	☐ Yes ☐ No	Barbiturates	☐ Yes ☐ No
Sedatives	☐ Yes ☐ No	Iodine	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Any Metals (nickel, mercury etc.)	☐ Yes ☐ No
Latex Rubber	☐ Yes ☐ 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	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐
Angina	☐	☐	Easily Winded	☐	☐
Stroke	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Anemia	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐
Epilepsy/Seizures	☐	☐	Cancer	☐	☐
Leukemia	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐
AIDS or HIV Infection	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐

Please list any other medical condition: _____