South Orange County Gastroenterology Inc. **Nader Mirhoseni, M.D.**
26691 Plaza, Suite 150 ~ Mission Viejo, CA 92691

Medical History

Name: _____Age: _____Date of Birth:_____ Date of Visit:_____

Reason for Consult: _____Referred by: _____

Medications: *(please list all of your current prescription and non-prescription medications, vitamins and supplements)*

_____

_____

Any Drug Allergies? □ No □ If Yes to what?_____

Past Medical History: *(Check Box and / or Add additional to bottom)*

- □ None
- □ Acid Reflux
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Barrett's Esophagus
- □ Bleeding Disorder
- □ Blood Clot
- □ Blood Transfusion
- □ Cancer : Type_____
- □ Chest Pain/Angina
- □ Chronic Anxiety
- □ Chronic Lung Disease
- □ Chronic Sinusitis
- □ Cirrhosis Of The Liver
- □ Colitis
- □ Colon Cancer
- □ Colon Polyps
- □ Crohn's Disease
- □ Depression
- □ Dementia
- □ Diabetes Type I II
- □ Diverticulitis
- □ Duodenal Ulcer
- □ Emphysema
- □ Fatty Liver
- □ Gallstones
- □ Glaucoma
- □ Gout
- □ Groin Hernia
- □ Heart Attack
- □ Heart Failure
- □ Heart Murmur
- □ Hepatitis __A__B__C
- □ Hiatal Hernia
- □ High Blood Pressure
- □ High Cholesterol
- □ High Triglycerides
- □ HIV or AIDS
- □ Irregular Heart Beat
- □ Irritable Bowel
- □ Kidney Disease
- □ Kidney Infection
- □ Kidney Stones
- □ Lupus
- □ Migraines
- □ Milk Intolerance
- □ Multiple Sclerosis
- □ Osteoporosis
- □ Ovarian Cyst
- □ Pancreatitis
- □ Parkinson's disease
- □ Peptic Ulcer
- □ Pneumonia
- □ Polio
- □ Psoriasis
- □ Radiation Therapy
- □ Rheumatic Fever
- □ Sciatica
- □ Seizures
- □ Sleep Apnea
- □ Stomach Ulcer
- □ Stroke Or Paralysis
- □ TB (Tuberculosis)
- □ Thyroid Disorder
- □ Ulcerative Colitis
- □ Other:

_____
_____
_____
_____

Past Surgeries / Procedures: *(Check Box and / or Add additional to bottom)*

- □ None
- □ Appendectomy
- □ Breast Surgery
- □ Colon Surgery
- □ Colonoscopy (Yr)____
- □ Colostomy
- □ C-Section
- □ EGD
- □ Gallbladder
- □ Hernia
- □ Heart Bypass
- □ Heart Stent
- □ Heart Valve
- □ Hemorrhoidectomy
- □ Hiatal Hernia Repair
- □ Hysterectomy
- □ Joint Replacement
- □ Kidney Surgery
- □ Liver Biopsy
- □ Obesity Surgery
- □ Ovary
- □ Prostate
- □ Sigmoidoscopy
- □ Stomach
- □ Thyroid
- □ Tonsillectomy
- □ Tubal Ligation
- □ Uterus
- □ Other:

_____
_____
_____

Family History: *(Check all that apply)*

	Father	Mother	Grandparents	Siblings	Other:_____
Colon Cancer	☐	☐	☐	☐	☐
Colon Polyp	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Other Diseases:					

Social History:

Marital Status: □ **Married** □ **Single** □ **Divorced** □ **Widowed**
Occupation: _____ □ **Unemployed** □ **Retired**
Smoking History: □ **Never** □ **Yes:** _____ **Packs per day for** _____ **Years**
Smoking Now? □ **No** □ **Yes:**
Alcohol Use: □ **No** □ **Yes: amount per day**_____ **for** _____**Years**
Drug Use: □ **No** □ **Yes: Specify drug and amount:** _____
Exercise: □ **No** □ **Yes: Specify:** _____
Hobbies: □ **No** □ **Yes: Specify:** _____
Recent Travel outside US: □ **No** □ **Yes; Where:** _____

Review of System: (check all that apply at the present time)

General
□ Fever or chills
□ Loss of appetite
□ Weight loss
□ Weight gain
□ Weakness or fatigue

Gastrointestinal
□ Abdominal distention
□ Abdominal pain/cramping
□ Belching
□ Black stool
□ Blood in stool
□ Change in bowel habit
□ Constipation
□ Diarrhea
□ Difficulty Swallowing
□ Fat intolerance
□ Full after eating small amounts
□ Gas/bloating
□ Heartburn
□ Indigestion
□ Hemorrhoids
□ Jaundice
□ Nausea or vomiting
□ Pain after swallowing
□ Rectal bleeding
□ Rectal pain
□ Regurgitation of food
□ Soiling / incontinence
□ Vomiting blood

Cardiovascular
□ Chest pain or tightness
□ Rapid or irregular heart rate
□ Swelling of the legs

Respiratory
□ Chronic cough
□ Wheezing
□ Shortness of Breath

Urinary
□ Pain or difficulty urinating
□ Frequent urination
□ Blood in urine
□ Incontinence of urine

Musculoskeletal
□ Stiff or Painful joints
□ Swollen joints
□ Back pain
□ Muscle pain

Hematologic
□ Frequent bruising
□ Bleeding doesn't stop easily

Endocrine
□ Heat or cold intolerance
□ Excessive thirst or urination
□ Steroid therapy (prednisone)

Genitoreproductive – male
□ Discharge from penis
□ Testicular lump or pain

Genitoreproductive – female
□ Heavy periods
□ Last menstruation date:_____

Dermatologic
□ Rash or Hives
□ Itching
□ Tattoos

Neurologic
□ Numbness or tingling
□ Dizziness or lightheadedness
□ Vertigo
□ Headaches
□ Weakness in arms or legs
□ Blurred vision
□ Difficulty with Memory

Psychiatric
□ Anxiety
□ Depression
□ Panic Attacks

Immunizations
□ Hepatitis A
□ Hepatitis B

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PATIENT INFORMATION FORM

FIRST NAME_____**MIDDLE INITIAL**_____ **LAST NAME**_____

ADDRESS: _____

CITY:_____ **STATE:**_____**ZIP:**_____

HOME#: _____**WK#:**_____**CELL#:** _____

BIRTH DATE: _____**SS#:**_____**LIC#**_____

AGE:_____**SEX: F M MARITAL STATUS: S M W D OTHER E-MAIL**_____

REFERRED BY:_____**FAMILY DOCTOR**_____

EMPLOYER:_____**OCCUPATION:**_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP:**_____

SPOUSE/NEAREST RELATIVE:_____**PHONE:**_____

SPOUSES EMPLOYER:_____**BIRTHDATE:**_____**SS#**_____

EMERGENCY CONTACT:_____**RELATION/PHONE:**_____

PRIMARY INSURANCE

COMPANY:_____

ID#:_____

GROUP#:_____

INSURED:_____

CO-PAY:_____

SECONDARY INSURANCE

COMPANY:_____

ID#:_____

GROUP#:_____

INSURED:_____

CO-PAY:_____

I guarantee payment to Nader Mirhoseni, MD. I authorize my insurance company(ies) to pay any and all charges rendered on my behalf to Nader Mirhoseni, MD. I will be responsible for and will guarantee on any and all charges, which may not be paid or covered by my insurance company(ies). I will make sure that my claims are paid promptly. I certify that the information given, including insurance coverage is complete and correct. I understand that payment in full may be required at the time of service. Any medical insurance that I may have is intended to protect me against financial loss. I understand that payment in full is my responsibility regardless of insurance coverage. I understand the returned check fee of $25.00. I understand there is a $25.00 fee for the office to complete requested forms. I understand if my account is submitted for collection I will be charged a 30% fee of the balance that is transferred to the collection agency.

Signature: _____ Date: _____

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Nader Mirhoseni, MD

Patient Record Disclosures

I wish to be contacted in the following manner (check all that apply)

Home Telephone:_____

Cell Phone:_____

____Ok to leave message with family and/or on machine

____Leave message with call-back number only

Work Telephone_____

____Ok to leave detailed message

____Leave message with call-back number only

Written Communication

____Ok to mail to home address

____Ok to Fax to_____

I authorize your office to disclose my health information to following people if needed (please print name and relationship to patient)

1)_____ 2)_____

_____ _____
Patient Signature Date

_____ _____
Print Name Date

Privacy Practices Acknowledgement

*I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____
Signature Date

*NOTE: A COPY OF OUR PRIVACY POLICY IS AVAILABLE UPON REQUEST, USES AND DISCLOSURES OF HEALTH INFORMATION MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.