Patient Information

Name: _____ Date of Birth_____/_____/_____

Address_____

CITY ST ZIP

Social Security: _____-_____-_____ Email _____

Home phone_____-_____-_____ Cell phone_____-_____-_____

Male Female Marital Status: Married Widow Single Minor Separated Divorced Partner

Driver's License #_____ Pharmacy Name & Phone #_____

Patient Employer_____Occupation_____

Primary Care Physician _____ PCP Phone #_____

In case of emergency who should be notified? _____ Phone_____

Primary Insurance

Insurance Name_____ Ins Address _____

CITY ST ZIP

Ins Phone _____-_____-_____ID #_____ Grp# _____

Insured name_____ Relationship to Patient: Self Spouse Parent Other _____

Insured Date of Birth_____/_____/_____ Soc Sec #_____-_____-_____

Additional Insurance

Insurance Name_____ Ins Address _____

CITY ST ZIP

Ins Phone _____-_____-_____ID #_____ Grp# _____

Insured name_____ Relationship to Patient: Self Spouse Parent Other _____

Insured Date of Birth_____/_____/_____ Soc Sec #_____-_____-_____

Assignment and Release

I certify that I, and/or my dependent{s} have insurance coverage with _____ and

Insurance Name-must be complete

assign directly to Dr. Guram all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all Insurance submissions.

The above named physician may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____/_____/_____

Patient signature Date

_____ _____

Please print Relationship to patient if a minor

Current Medications:

Please indicate which (if any) of the following blood-thinners you are taking:

____Aggrenox	____Lovenox	____Ticlid	____None
____Coumadin	____Plavix	____Warfarin	
____Effient	____Pletal	____Xarelto	
____Eliquis	____Pradaxa	____Other	

Please List all medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Do you have any known drug allergies? ____YES ____NO

If so, please list all medications you are allergic to:

Medication Name	Allergic reaction type
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Topical Allergies:

____Iodine ____latex ____Tape

Are you allergic to IV Contrast? ____YES ____NO

Any new medications:_____

Any new surgeries:_____

Any change in health:_____

PATIENT INTAKE FORM

Patient Name:_____

Weight:_____ B/P:_____ P:_____ Temp:_____ RR:_____

Date:_____

Please check (x) if you are experiencing or have any of the following:

General:
____Fatigue
____Fever
____Unintentional Weight Loss
____Unintentional weight Gain
____Daytime Somnolence
____Fogginess of Tasks
____Inability to Complete Tasks
____Insomia
____None Dry Mouth
____Visual Changes
____None

Cardiovascular:
____Chest Pain
____Palpitations
____None

Pulmonary:
____Snoring
____Shortness of breath
____Cough
____Obstructive sleep apnea
____Snore at night
____Use CPAP machine
____Smoker
____Chronic Obstructive
____Pulmonary Disease
____None

Gastrointestinal:
____Constipation:
____Diarrhea:
____Nausea:
____Heartburn:
____Blood in Stool:
____None

Genitourinary:
____Difficulty Urinating
____Painful Urination
____Blood in Urine
____Increased urinary frequency
____None

Endocrine:
____Heat Intolerance
____Cold Intolerance
____Increased Thirst
____None

Neurological:
____Glaucoma
____Difficulty Walking
____Headaches
____Numbness
____Seizures
____Strokes
____Weakness
____None

Musculoskeletal:
____Neck Pain
____Back Pain
____Muscle Aches
____Joint Pain
____Joint Swelling
____None

Hematologic:
____Clotting Difficulties
____Easy Bledding
____Easy Bruising
____None

Psychiatric:
____Depression
____Anxiety
____Thoughts harming oneself
____Thoughts harming others
____Hallucinations
____None

Other:
____Myocardial infarction
____Heart Attack
____Heart rhythm abnormalities
____Abnormal EKGS
____History of coronary stents
____Diabetes
____Steroid use
____Blood thinning medication
Example: Aspirin,Plavix,
Clopidogrel, Heparin,Lovenox
Other:_____
____None

Health Assessment for Women

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

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