Naima Zaheer, MD, PLLC

Infectious Diseases
5770 S Durango Dr., Ste 105, Las Vegas, NV 89113
Phone: 702-737-0740 / Fax: 833-527-8800

Today's Date: _____

Demo Information

Name: _____ DOB: ____-____-_____ Marital Status: S M D W

Address: _____ City: _____ St: _____ Zip: _____

Cell phone (_____) _____-_____ Home phone (_____) _____-_____

Email _____@_____

Preferred method of contact: Phone Text Email Other: _____

Work related injury _____Auto Accident _____ Date of injury/accident _____/_____/_____

Primary Insurance: _____ Policy Number: _____

• Policy Holder: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Secondary Insurance: _____ Policy Number: _____

• Policy Holder: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Pharmacy Name: _____ Pharmacy Phone Number: (_____)_____-_____

Pharmacy Address (or cross streets): _____

Allergies: _____

Emergency contact: _____ Relationship: _____ Cell/Home #: _____

♦♦♦ I understand that I may be charged **$30.00** for any appointment that is cancelled or broken without 24 hour notice. ♦♦♦

_____ _____
Patients Signature Date

Reviewed and entered: _____

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Today's Date: _____

PATIENT HISTORY QUESTIONNARIE

Name: _____ **Date of Birth** ____/____/_____ **Sex:** M F

Occupation: _____

Marital Status: Single Married Divorced Widowed Partner

Race/Ethnicity:

African American	Asian	Native American	Native Hawaiian	Other: _____
Caucasian	Hispanic	Alaskan Native	Other Pacific Islander	

PAST MEDICAL HISTORY: Have you ever had any of the following? (Circle)

Headache	Pneumonia	Hepatitis A B C	SLE (Systemic lupus erythematosus)
Abdominal Pain	Asthma	Chronic Liver Disease	Migraine headache
Anxiety	Chronic Obstructive	Chronic Kidney Disease	TIA (Transient ischemic attack – mini stroke)
STD	Pulmonary Disease	Nephrolithiasis (Kidney Stones)	CVA (Cerebrovascular accident – stroke)
Cataract	Emphysema	Urinary Tract Infection	Dementia
Glaucoma	Esophageal Reflux	Hyperlipidemia (High cholesterol)	Depression
Hearing Loss	Gastric Ulcer	Obesity	Nonorganic sleep apnea
Coronary Artery Disease	Colitis	Thyroid Disorder	Tuberculosis
Chest Pain	Polyps of Colon	Osteoporosis	Hematologic Disorder
Congestive Heart Failure	Diverticulitis of Colon	Diabetes mellitus	Anemia
Hypertension	Irritable Bowel Syndrome	Polycystic ovarian syndrome	Cancer
DVT of lower extremity	Hemorrhoids	Psoriasis	Colon Cancer
Edema	Cholelithiasis (Gallstones)	Arthritis	Breast Cancer
Heart Disease	Cholecystitis (Gallbladder inflammation)	Gout	Sickle Cell

Other: _____

OPERATIONS: (Give date or age)

Tonsillectomy _____	Hemorrhoidectomy _____	Prostatectomy _____
Heart surgery _____	Cholecystectomy _____	Back surgery _____
Varicose vein ligation _____	Hernia Repair _____	Hip Surgery _____
Mastectomy _____	Vasectomy _____	Knee Surgery _____
Splenectomy _____	Hysterectomy _____	Other _____
Appendectomy _____	Cesarean section _____	_____

RECENT EVENTS: (Dates & hospital names if applicable)

Staph Infection _____	Strep Infection _____
History of MRSA _____	Upper Respiratory Infection_____

RECENT RADIOLOGY / PROCEDURES / LABS / CULTURES: (Dates & where they were done)

CT / MRI / X-Rays _____	Labs _____
Cultures (Sputum/Blood/Urine/Wound) _____	Biopsies _____
_____	

CURRENT MEDICATIONS: (Give name, dosage amounts & number of times taken per day)

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

ALLERGIES: (Medications, Foods, Pollens – **Describe Reaction**)

1. _____ 3. _____
2. _____ 4. _____

IMMUNIZATIONS: (Approximate date or age)

PPD _____ | Tetanus _____ | Flu Vaccine _____
Pneumonia _____ | Hepatitis _____ | Shingles _____
Other: _____

MEMBERS OF YOUR HOUSEHOLD:

Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____

HABITS: (Check any that apply)

____ Smoke or chew tobacco (how much?) ____ ____ Caffeine (cups) ____
Past or Current User
____ Drink Alcohol (how much?) _____ ____ Recreational Drugs _____
Beer Wine Hard alcohol ____ Never used
____ Special Diet ____
____ Exercise (how much?) Regularly Sedentary

Highest educational level achieved? _____

FAMILY HISTORY:

	Age	Alive	Deceased	Health Problems
Father				
Mother				
Sister				
Sister				
Brother				
Brother				
Children	M or F			
Children	M or F			

Primary Care Doctor _____ Phone number _____

Why were you referred to Naima Zaheer, MD and what is your main concern today?

_____

_____

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Today's Date: ________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their parent(s), grandparents, care givers or other to call and discuss medical information, request prescriptions, medical records, and results of tests and pick up forms, etc. Under the requirement of HIPAA we are NOT allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

I, ____, date of birth _______/_______/__________,
(Print your Name)

Authorize representatives of Infectious Diseases Consultants, to share and/or release information to:

1) ____________________________________ Relationship ____________________________

Check all that apply:
- □ Regarding appointment, time & date
- □ Discuss medical care, an issue or concern
- □ Discuss lab results
- □ Request and pick up/fax prescriptions/forms

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2) ____________________________________ Relationship ____________________________

Check all that apply:
- □ Regarding appointment, time & date
- □ Discuss medical care, an issue or concern
- □ Discuss lab results
- □ Request and pick up/fax prescriptions/forms

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3) ____________________________________ Relationship ____________________________

Check all that apply:
- □ Regarding appointment, time & date
- □ Discuss medical care, an issue or concern
- □ Discuss lab results
- □ Request and pick up/fax prescriptions/forms

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I understand that I have the right to change this authorization, in writing at any time by sending a written notification to this office.

____ ________________________________
Patient Name (Print) **Date**

____
Signature of Patient

If you think we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information we want you, your family or care giver to speak with us. If you complain to us, your care will not be affected in any way. It is our goal to give you the best care while respecting your privacy.

Thank you
Management


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Today's Date: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name(s): _____ Social Security #: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

****NOTE: There will be a fee of 60 cents per page for ALL medical records released directly to the patient. ****

THIS AUTHORIZATION WILL EXPIRE ONE YEAR AFTER IT IS SIGNED.