

LISA AIRAN M.D.  
PATIENT INFORMATION FORM

REASON FOR VISIT \_\_\_\_\_ DATE OF VISIT \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MR/MRS/MISS \_\_\_\_\_ PREFERRED FIRST NAME \_\_\_\_\_ HOME PHONE (\_\_\_\_\_) \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MIDDLE NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT. \_\_\_\_\_ MOBILE PHONE (\_\_\_\_\_) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PAGER (\_\_\_\_\_) \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ \* MALE \* FEMALE OTHER (\_\_\_\_\_) \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ \* SINGLE \* MARRIED \* OTHER (\_\_\_\_\_) \_\_\_\_\_ FAX \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

**EMERGENCY CONTACT**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_  
HOME PHONE

(\_\_\_\_\_) \_\_\_\_\_  
WORK PHONE

**EMPLOYMENT INFORMATION**

- \* FULL TIME    \* FULL TIME STUDENT    \* RETIRED
- \* PART TIME    \* PART TIME STUDENT    \* OTHER

OCCUPATION \_\_\_\_\_

COMPANY OR SCHOOL \_\_\_\_\_

MANAGER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

MAY WE CALL YOU AT WORK? \* YES \* NO

MAY WE LEAVE A MESSAGE FOR YOU AT HOME? \* YES \* NO

MAY WE EMAIL TO THE ADDRESS PROVIDED? \* YES \* NO

HOW DID YOU LEARN ABOUT DR. AIRAN?

\* MAGAZINE (WHICH ONE): \_\_\_\_\_

\* TELEVISION

\* FRIEND OR RELATIVE

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_  
PHONE

NAME OF INSURED \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

# LISA AIRAN M.D.

## PATIENT INFORMATION FORM

### PATIENT HEALTH DISCLOSURE STATEMENT

Please answer all questions.

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you under a doctor's care? \_\_\_\_\_ yes \_\_\_\_\_ no      If yes, for what condition? \_\_\_\_\_

Illnesses (List any serious or chronic illness):

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ |          |

Operations (List all previous surgery):

- |          |              |
|----------|--------------|
| 1. _____ | 2. _____     |
| 3. _____ | 4. _____     |
| 5. _____ | Other: _____ |

Habits:

Alcohol:	Never	Rarely	Several Times a Week	Daily			
Tobacco:	Never	Rarely	Daily	Packs per day _____	How long? _____	Cigar/Pipe	Yes      No

Do you have (Circle):	Dentures	Capped teeth	Bridges	Loose teeth	Chipped teeth	Diseased gums
	Contact lenses	Glasses	Hearing aid	Other prosthetic devices: _____		

Important Medical Conditions: Have you ever had or received treatment for any of the following?

(Please circle)

Hepatitis, jaundice, cirrhosis, or liver disease?	Yes	No	Blood transfusions?	Yes	No
Asthma, TB, pneumonia, emphysema or chest disease?	Yes	No	HIV or AIDS?	Yes	No
Heart attack, angina, palpitations or irregular heart beats?	Yes	No	Anemia or blood disorder?	Yes	No
Shortness of breath, or fainting spells	Yes	No	Chronic or recent cough?	Yes	No
Rheumatic fever or congenital heart disease?	Yes	No	Abnormal or excessive bleeding?	Yes	No
High blood pressure or Low blood pressure?	Yes	No	Hives, rashes, or skin diseases?	Yes	No
Kidney failure, kidney or prostate problems?	Yes	No	Alcohol abuse or alcoholism?	Yes	No
Migraines, headaches or chronic head pain?	Yes	No	Drug abuse or addictions?	Yes	No
Eating disorder, anorexia, or bulimia?	Yes	No	Diabetes, or abnormal "blood sugar"?	Yes	No
Lupus, arthritis, or autoimmune disease?	Yes	No	Thyroid problems?	Yes	No
Psychological or emotional problems?	Yes	No	Xray treatments or radiation therapy?	Yes	No
Nervous breakdown or personality disorder?	Yes	No	Adverse or unusual reaction to anesthesia?	Yes	No
Phlebitis, blood clots or varicose veins?	Yes	No	Abnormal healing or poor scar formation?	Yes	No
Stroke, seizures, Bell's palsy or neurological problems?	Yes	No	Edema, persistent or unusual swelling?	Yes	No
Shingles, cold sores, fever blisters or oral herpes?	Yes	No	Venereal disease?	Yes	No
Stomach ulcers?	Yes	No	Anxiety or "panic attacks"?	Yes	No
Recent weight gain or loss?	Yes	No	Anaphylaxis?	Yes	No

Other Medical Conditions (Explain): \_\_\_\_\_

# LISA AIRAN M.D.

## PATIENT INFORMATION FORM

Drugs and Medicines: Have you, within the last 6 months, taken any of the following?

(If yes, please circle)

Accutane	Yes	No	Anticoagulants or blood thinners?	Yes	No
Cortisone, prednisone, or ACTH?	Yes	No	Pain pills?	Yes	No
Diuretics or water pills?	Yes	No	Homeopathic or herbal medicines?	Yes	No
Heart medication, Digitalis, Lanoxin?	Yes	No	Stimulants, appetite suppressants, diet pills?	Yes	No
Blood pressure medication?	Yes	No	Sedatives, tranquilizers, or sleeping pills?	Yes	No
Nitroglycerin?	Yes	No	Antidepressants, antipsychotics or nerve pills?	Yes	No
Steroids or body building drugs?	Yes	No	Recreational or illegal drugs?	Yes	No
Headache or migraine medications?	Yes	No	Phen-Phen, or Redux?	Yes	No
Seizure medication?	Yes	No	Birth Control Pills?	Yes	No
Antibiotics?	Yes	No	Asthma Meds, inhalers etc?	Yes	No
Insulin, Orinase or similar drugs?	Yes	No			
Please List Medications Taken: _____					

Medications that cause bleeding: Have you taken any of the following in the last 2 weeks?

(If yes, please circle)

Aspirin or aspirin containing medications?	Yes	No	Vitamin E? (excluding multivitamins)	Yes	No
Ibuprofen, (Motrin, Advil, Nuprin) containing products?	Yes	No	Anti-inflammatories or muscle relaxants?	Yes	No

Allergies and Sensitivities: Is there any history of skin reaction or other illness following the administration of:

(If yes, please circle)

Penicillin, Sulfa, or other antibiotics?	Yes	No	Tetanus toxoid or serum?	Yes	No
Morphine, Codeine, Demerol or narcotic?	Yes	No	Tincture of Benzoin?	Yes	No
Novocaine, Lidocaine, or local anesthetics?	Yes	No	Adhesive tape?	Yes	No
Iodine, Betadine, Chlorhexidine, or PhisoHex?	Yes	No	Latex rubber?	Yes	No
Other drugs or medicines? (List):	Yes	No	Dairy products?	Yes	No

Pregnancy:

Are you now pregnant?	Yes	No	Are you breast feeding?	Yes	No
Number of pregnancies? _____			Number of children _____		
Are you sexually active?	Yes	No	Are you currently using birth control?	Yes	No

I certify that the above is true and correct. I realize that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing either false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date