



ANN M WIERMAN MD, LTD

3150 N Tenaya Way Suite 200

Las Vegas, NV 89128

Phone: (702) 749-3700

Fax: (702) 749-3706

NEW PATIENT HISTORY FORM

DATE:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: (last, first, middle)		SSN:	
DOB:		SEX:	
Address:			
		City	State
		Zip Code	
Home Phone #:		Work Phone #:	
Cellular #:		Pref. Communication:	Fax #:
Email:			
May we email you? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave message on your voice mail?			
Race: <input type="checkbox"/> American Indian/Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Black African American <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unreported/Refused to Report <input type="checkbox"/> White			
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino <input type="checkbox"/> Unreported/Refused to Report		Preferred Language:	
		Interpreter?	
Name of Employer:		Work Phone:	Occupation:
Primary Care Physician:		Phone #:	Fax #:
Pharmacy:		Pharmacy Address:	
Pharmacy Phone #:		Fax #:	
Referring Physician & Contact Info:			
Please list any additional Physicians you see:			
Power of Attorney (If applicable):			
Name:		Relation to patient:	Phone #:

Patient's Initial:

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INSURANCE INFORMATION

(Please Print)

Today's Date:		
Patient's Name:		

LAST

FIRST

MIDDLE

Primary Insurance:		
Are you the main policy holder?	YES NO	Name of primary policy holder:
Policy number:	Effective Date:	
Group number:	Policy holder's SS#:	
Patient's relationship to subscriber:	DATE OF BIRTH: (Please indicate)	

Secondary Insurance:		
Are you the main policy holder?	YES NO	Name of primary policy holder:
Policy number:	Effective Date:	
Group number:	Policy holder's SS#:	
Patient's relationship to subscriber:	DATE OF BIRTH: (Please indicate)	

IN CASE OF EMERGENCY		
Name of friend or relative (not living w/you):	Relationship to patient:	Contact Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ann M Wierman MD, LTD. Or Insurance company to release any information required to process my claims.

Patient/Guardian Signature_____
Date



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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

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

☐ All healthcare information

☐ Other: _____

☐ 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: _____



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PROVIDING QUALITY CARE TO ALL OF OUR PATIENTS IS OUR MISSION

As cancer and hematology specialist, we know that modern cancer and hematology care may be expensive. We will work with you and your insurance company to provide the most effective treatment options at the minimal cost to you.

Ann M Wierman MD, LTD provides verification and review of your insurance benefits. If you feel your estimated cost is not affordable, please inform the office immediately before treatment starts.

Our office requires that you provide your current health insurance identification card and ID to all appointments; complete all required paperwork in a timely manner. Please note that payment for co-pays, deductibles and balances not paid by your insurance company are your responsibility.

You are responsible for ensuring Ann M Wierman MD, LTD has your most current health insurance and billing information. We ask that you notify us either in person or via phone or mail any time you have a change in your insurance or billing information. If you lose insurance coverage, we must be notified immediately to avoid incurring outstanding balance.

Co-payments are due at the time of service. We may also ask for payment on any outstanding patient balances at the practice site. Ann M Wierman MD, LTD accepts cash, checks, and cards.

I understand the above policies and have had the opportunity to discuss any questions I may have.

Patient/Responsible Party Signature

Date

Witness

Date

PATIENT NAME:

REASON FOR THE VISIT:

Medical History:
(Check all that apply to
you currently or in the
past)

- | | |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Cirrhosis of Liver |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C When? |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Kidney Stone |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Kidney Disease / Failure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent Urinary Tract Infection |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Enlarged Prostate |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lupus-Autoimmune |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Raynaud's Syndrome |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Heart Attack-MI | <input type="checkbox"/> Chronic back pain |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Heartburn / Reflux | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic Lung (COPD) | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Pneumonia / Bronchitis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> TB (Tuberculosis) | <input type="checkbox"/> Glaucoma / Cataracts |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Cancer Where? Doctor? |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Problem with Anesthesia |
| <input type="checkbox"/> GERD / Heartburn | <input type="checkbox"/> Other |

Details of Medical History:

Patient's Initials:

PATIENT NAME:			
CANCER HISTORY			
Date Diagnosed:			
Type of Cancer:			
Treatment:			
Treating Physician:			
PAST SURGICAL HISTORY			
<input type="checkbox"/> Coronary Bypass	Date:		
<input type="checkbox"/> Angioplasty	Date:		
<input type="checkbox"/> Pacemaker	Date:		
<input type="checkbox"/> Cardiac Valve Surgery	Date:		
<input type="checkbox"/> Hemorrhoidectomy	Date:		
<input type="checkbox"/> Prostate operation	Date:		
<input type="checkbox"/> Hernia Repair	Date:		
<input type="checkbox"/> Tonsillectomy	Date:		
<input type="checkbox"/> Mastectomy	Date:		
<input type="checkbox"/> Lumpectomy	Date:		
<input type="checkbox"/> Knee Replacement	Date:		
<input type="checkbox"/> Rotator Cuff Repair	Date:		
<input type="checkbox"/> Cataract	Date:		
<input type="checkbox"/> Gallbladder Surgery	Date:		
<input type="checkbox"/> Hysterectomy	Date:		
<input type="checkbox"/> Prostatectomy	Date:		
<input type="checkbox"/> Appendectomy	Date:		
<input type="checkbox"/> Hip Replacement	Date:		
SOCIAL HISTORY			
Tobacco Use: (Present or Past)			
<input type="checkbox"/> Never Smoked		<input type="checkbox"/> Marijuana	
<input type="checkbox"/> Chewing Tobacco			
<input type="checkbox"/> Quit Smoking	When?	How many year/s?	How many packs?
<input type="checkbox"/> Currently Smoking	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars	How many year/s?	How many packs?
Alcohol History: (Present or Past)			
<input type="checkbox"/> Non Drinker			
<input type="checkbox"/> Beer	Number of bottles per _____ <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month		
<input type="checkbox"/> Wine	Number of bottles per _____ <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month		
<input type="checkbox"/> Liquor	Number of bottles per _____ <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month		
Patient's Initials:			

PATIENT NAME:		
Influenza Shot: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Influenza Shot:	
Pneumococcal Shot: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Pneumococcal Shot:	
Shingles Shot: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Shingles Shot:	
Last EGD: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last EGD:	
Colonoscopy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Colonoscopy:	Findings:
Sigmoidoscopy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Sigmoidoscopy:	Findings:
Bone Density: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Bone Density:	Findings:
Pelvic Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Pelvic Exam:	Findings:
FAMILY MEDICAL HISTORY (Indicate any family members with cancer, blood disease, or other disease)		
	Age	Disease
Grandfather		
Grandmother		
Father		
Mother		
Siblings		
Children		
In your opinion, are there any diseases that run in your family? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list:		
OB/GYN HISTORY		
How many times have you been pregnant?	How many live births have you had?	
Your age at the birth of your first child?	Any history of miscarriages or abortions?	
Did you breast feed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long did you breast feed?	
Are you using birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please include type:	
Any complications during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you wish to become pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How old were you when you began to menstruate?		
Are you still having periods? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, first day of your last period:		
If no, how old were you when you stopped having periods?		
Are you experiencing of the below symptoms?		
<input type="checkbox"/> Menstrual Pain		
<input type="checkbox"/> Bleeding between periods		
<input type="checkbox"/> Spotting between periods		
<input type="checkbox"/> Excessive bleeding		
Date of last Mammogram:		
Date of last PAP Smear:		
Have you had an abnormal PAP test? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list date and type of any treatment(s) received:		
Patient's Initials:		

PATIENT NAME:		
REVIEW OF SYMPTOMS (Please check any current symptoms you have)		
General	Cardiovascular	Allergies/Immunology
<input type="checkbox"/> Weight, Loss How much:	<input type="checkbox"/> Chest Pain/Angina Pectoris	<input type="checkbox"/> History of Chronic Infections
<input type="checkbox"/> Fever, Max temperature:	<input type="checkbox"/> Palpitation/ Heart Murmur	<input type="checkbox"/> History of Allergies
<input type="checkbox"/> Chills	<input type="checkbox"/> Irregular Heart Beat Pressure	Endocrine
<input type="checkbox"/> Night Sweats	Respiratory	<input type="checkbox"/> Heat or Cold Intolerance
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chronic or Frequent Cough	<input type="checkbox"/> Excessive Skin Dryness
Eyes	<input type="checkbox"/> Bloody Sputum	<input type="checkbox"/> Excessive Thirst or urination
<input type="checkbox"/> Wear Glasses/Contact Lenses	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Weight Problem
<input type="checkbox"/> Blurred Vision	Genitourinary	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Kidney Stones	Breast
Ears, Nose, Throat	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Skin Reaction
<input type="checkbox"/> Hard of hearing or deaf	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Breast Lump/Mass
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Burning or Pain on Urination	<input type="checkbox"/> Nipple Discharge
<input type="checkbox"/> Enlarged lymph nodes	Musculoskeletal	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Chronic Sinus Problem	<input type="checkbox"/> Joint Pain/ Arthritis	<input type="checkbox"/> Breast Pain
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Muscle or Joint Weaknesses	<input type="checkbox"/> Skin Lesion
<input type="checkbox"/> Mouth Pain/Sores	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Vaginal Discharge
Changes/Difficulty	<input type="checkbox"/> Bone Pain	<input type="checkbox"/> Menstrual Irregularity or Abnormal Bleeding
<input type="checkbox"/> Taste	<input type="checkbox"/> Muscle Aches	Blood
<input type="checkbox"/> Smell	Neurological	<input type="checkbox"/> Anemia
<input type="checkbox"/> Voice	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Low White Cells
Gastrointestinal	<input type="checkbox"/> Arm or Leg Weakness	<input type="checkbox"/> Too many CBC
<input type="checkbox"/> Difficult of Painful Swallowing	<input type="checkbox"/> Light-Headed/Dizzy/Fainting Spells	<input type="checkbox"/> Low Platelets
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Headache	<input type="checkbox"/> Too many Platelets
<input type="checkbox"/> Nausea	<input type="checkbox"/> Tremors	<input type="checkbox"/> Too many Red Cells
<input type="checkbox"/> Vomiting	Skin	<input type="checkbox"/> CLL Leukemia
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Rashes or Itching	<input type="checkbox"/> CML Leukemia
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Change in skin color or Moles	<input type="checkbox"/> AML Leukemia
<input type="checkbox"/> Lump or Sensation in Throat	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> ALL Leukemia
<input type="checkbox"/> Food Sticking	<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> MDS
<input type="checkbox"/> Bloating	Psychiatric	<input type="checkbox"/> Hypergammaglobulinemia
<input type="checkbox"/> Belching	<input type="checkbox"/> Anxiety/Agitation	<input type="checkbox"/> MGUS
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression	<input type="checkbox"/> Multiple Myeloma
<input type="checkbox"/> Constipation	<input type="checkbox"/> Crying for no reason	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Black or tarry Stools	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood in Stool
<input type="checkbox"/> Hidden Blood in Stool	<input type="checkbox"/> Drug Problem (Now/Past)	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Excessive Rectal Gas/Flatus	Hematologic	<input type="checkbox"/> Black Stool
<input type="checkbox"/> Loss of Stool/Fecal Accident	<input type="checkbox"/> Easy Bruising	
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Gum or Nose Bleeding	
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Blood Transfusion in past	
Patient's Initials:		

PATIENT NAME: _____

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct information.

DRUG ALLERGIES (List all medication allergies)

Medication	Reaction

Are you allergic to: ☐ Iodine ☐ Latex ☐ Shellfish ☐ CT Scan Dye/IV Contrast ☐ Eggs ☐ Peanuts

☐ Other: _____

Type of Reaction:

PHARMACY:

ADDRESS:

PHONE: _____

LIST ALL MEDICATIONS (including non-prescription that you are currently taking)

[illegible]

Patient's Initial: _____