DANIEL ZACHARIAS, M.D.
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SHORT HILLS, NJ 07078
973-912-0006
daniel@danielzacharias.com

Patient's name _____

Address _____

_____

PHONES: home _____ cell _____

work _____ email _____

date of birth

emergency contact name and number

INSURANCE:

policyholder name policyholder birthday

patient's relationship to the policyholder

policy number

group number

address of insurance co

I hereby assign, transfer and set over to Dr. Zacharias, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I consent to review of my previous medical information including prescription history. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature: _____ date: _____

The following pages of medical items are listed to cue issues to go over at your appointment. This is only a guide to identify issues to discuss. Please evaluate each item but you don't need to answer each of them. If you need more space, use more space!

The main reason for making this medical appointment:

_____

_____

Medical problems and treatments:

_____

_____

_____

Past/Current Medical Conditions

Anemia
Arthritis.
Asthma.
Bronchitis.
Cancer.
Chronic fatigue syndrome.
Crohn's disease or ulcerative colitis.
Dental/Periodontal disease
Diabetes.
Emphysema.
Epilepsy, convulsions, seizures.
Gallstones.
Heart disease.
Heart failure.
Heart irregularity
Hepatitis.
Hyperlipidemia (high cholesterol, triglycerides).
High blood pressure (hypertension).
Irritable bowel.
Lyme, tickborne illness
Kidney stones.
Mononucleosis/Epstein Barr virus
Neurologic disorder (e.g. MS, Parkinson's, neuropathy)

Pneumonia.
Rheumatic fever.
Sinusitis.
Sleep apnea.
Stroke.
Thyroid disease.
Transfusions:
Others:
Childhood illnesses:

Injuries/trauma/fractures:

Surgeries:
appendectomy.
Cataracts
Gallbladder.
Hernia.
Hysterectomy.
Tonsillectomy.
Other:

Pregnancies/deliveries:

Testing

barium enema or lower G.I.
Upper G.I.
Upper Endoscopy
Bone scan.
Bone density
CT scan
Colonoscopy/sigmoidoscopy
EKG.
stress test
mammogram
breast ultrasound
MRI.
Ultrasound
X-rays
Sleep study
Abnormal blood tests
Genetic Testing
stool testing
Other.

Hospitalizations: where/when/why?

Allergies to medications:

When was last:

Dentist:
Ophthalmologist:
Colonoscopy:
Occult Blood test:
PAP:
Mammogram:
Breast ultruasound
Densitometry:
PSA:
Tetanus:
Pneumovax:
Prevnar 13:
Flu vaccination:
Other Immunizations:
PPD (TB test)
dermatology exam:

Have "living will" or "advanced directives"

Do you have any pets or animals.

Have you traveled outside of America?

Any recent major life changes/losses?

How important is religion or spirituality for you?

How much time have you lost from work/school in the past year because of health?

Have you been subjected to abuse or violence?

Number of courses of the antibiotics in the last five years?

Steroids (prednisone) in the past?

Are you on a special diet?
Have you ever done an elimination diet?
What is your typical dietary intake?:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you eat after dinner?

How many times per week do you eat at a restaurant?

How many helpings of vegetables do you have in a day?

Do you eat junk "food" (Candy, cake, ice cream etc.)

Number of cups of caffeinated/decaf coffee?

Number of cups of tea?

Problem with weight?

Are there any foods that give you untoward reactions (lactose, wheat, corn, fat)?

Are there any foods that make your symptoms worse.?

Are there any foods that make you feel better?

Does skipping a meal affect your symptoms?

Do you crave or binge on food?