WELCOME TO AVEON HEALTH!

I am honored that you chose Aveon Health as your Healthcare Home and I am committed to providing you with the best care I can. My hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health. I will share my medical expertise with you, and I hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being. Few of us, myself included, have a completely healthy lifestyle, but each day we can take a step closer to a healthier life.

Here are some important steps you can take toward better health:

- Don't smoke cigarettes or use other tobacco products.
- Drink alcohol in moderation, if at all, and never drive when you've been drinking.
- Eat a healthy, balanced diet.
- Exercise at least three times a week.
- Properly care for chronic conditions.
- Learn ways to deal with stress and tension.

It will give us great pleasure to work with you on these goals, either through our own expertise or through patient education materials we will provide.

We want everyone to be involved in maintaining a healthy lifestyle. Everyone who joins our practice should start by having a complete physical exam followed by periodic check-ups to test for a few specific diseases.

I look forward to working with you as your family doctor. Please contact me whenever you'd like to talk about anything you think may be affecting your health. It's my hope that we can have a relationship where the lines of communication are open and communication goes both ways. Let's work together to help you live the healthy and happy life that you deserve.

Sincerely,

Dr. Sam S. Fereidouni

Patient Information Form

Patient Full Name_____ Date of Birth_____

Mailing Address_____ City_____ State_____ Zip_____

Home phone_____ Cell phone_____

Race_____ Ethnicity_____

If patient is a minor, parent or guardian name_____

Marital status _____Email_____

Emergency contact name _____ Phone #_____

Relation to patient _____

How did you hear about us? _____

Release of Test Information

I give consent for the following individual to be able to access my health information and speak with Aveon Health doctors and staff members about my care, condition, and treatments:

Name: _____ Relationship to Patient: _____

Phone #: _____

I give consent for Aveon Health to leave a detailed messages to be left on my voice mail? **Yes / No**

I give consent for Aveon Health to contact myself at my place of employment **Yes / No**

If yes Employment Phone Number:_____

Signature _____ Date_____

Health Questionnaire

Patient Full Name:_____

Medication Allergies: _____

Current Alcohol Use: **Y / N** Drinks per week: _____

Current Tobacco Use: **Y / N**

Past Tobacco Use: **Y / N** Date Quit:_____

Current Narcotic Abuse: **Y / N** Type of Narcotic: _____

Past Narcotic Abuse: **Y / N** Date Quit:_____

Marital status:_____ Spouse Name: _____

Do You Exercise: Days per week _____ Exercise type: _____

Sexually active? **Y / N**

Sexual Partners: **Male / Female / Both**

Form of protection_____

Last physical exam date: _____

Previous Dr. Name:_____ Phone Number: _____

Do you see any specialist? **Y / N** if so what type of specialist?

_____

Health Questionnaire Continued

Past Medical History: Do you or have you had any of these problems?

☐ Irregular heart beat ☐ Stroke ☐ Blood clot ☐ High Cholesterol ☐ Pneumonia

☐ High blood pressure ☐ Heart attack ☐ Heart murmur ☐ Asthma ☐ Gallstones

☐ Emphysema ☐ Pulmonary embolism ☐ Tuberculosis ☐ Sleep apnea ☐ Anxiety

☐ Chronic bronchitis ☐ Liver Disease ☐ Hemorrhoids ☐ Stomach ulcer ☐ Gout

☐ Diverticulitis ☐ Prostate disease ☐ Fracture ☐ Arthritis ☐ Dementia

☐ HIV ☐ Blood transfusion ☐ Anemia / low blood ☐ Depression ☐ Diabetes

☐ Bleeding disorder ☐ Seasonal Allergies ☐ Alcohol abuse ☐ Substance abuse ☐ Back Pain

☐ Congestive heart failure ☐ Thyroid Disease ☐ Kidney disease or infections

☐ Have you ever had falling episodes ☐ Use of aspirin or any Antithrombotic ☐ Kidney disease or infections

☐ Ulcerative colitis/Crohns ☐ Skin Disease, List Type:_____ ☐ Cancer, List Type:_____

☐ Date of last influenza vaccine:_____ ☐ Date of last pnumococcal vaccine:_____

☐ Date of last colorectal screening:_____ ☐ Date of last mammogram screening:_____

☐ Date of last DM eye exam:_____

Surgical history: Have you had any surgeries?

Surgery	Date

Family History: Do any close relatives have the following?

KEY: **M** = Mother **F** = Father **PGF** = Paternal Grandfather **MGF** = Maternal Grandfather **PGM** = Paternal Grandmother **MGM** = Maternal Grandmother **B** = Brother **S** = Sister

Condition	Yes	No	Who	Condition	Yes	No	Who
Alcohol Abuse				Glaucoma			
Anemia				Heart Attack			
Anxiety				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Liver Disease			
Cancer Type				Prostate Disease			
Cholesterol				Stroke			
Depression				Thyroid Disorder			
Diabetes				Tuberculosis			
Epilepsy				Other			
				Other Specify			