NADIR M. ALI, M.D., P.L.L.C.
CLIENT REGISTRATION FORM

How did you hear about us?	

CLIENT INFORMATION

Prefix: Select One Below	**Client's Last Name:**	**First Name:**	**MI:**

Social Security #: (optional)	**Date of Birth:**	**Sex:**	**Marital Status:**

Email Address:			
Race / Ethnicity: Select One from Drop-Down box		**Other:**	

Home Address:	**City, State, Zip Code:**
Mailing Address:	**City, State, Zip Code:**

Home Phone:	**Mobile Phone:**	**Work/Other:**
Employer:	**Occupation:**	**City & State:**

By signing below, I (the Client) agree to the terms that neither I, nor the office, will submit a claim to my insurance company. I understand that I will not be reimbursed by my insurance company for the services rendered. I understand that I am expected to pay for all professional services at the time of the session. In addition, I understand that this acknowledgement is to remain in effect until revoked by me in writing. ----------------------------

Client Signature:	**Today's Date:**

Nadir M. Ali, M.D., PLLC

Medical Questionnaire

Client Name: ____________________ **Age:** _____ **Height:** _______ **Starting Weight:** _________ **Current Weight:** ___________

Reason for Visit: ____

Personal Medical History

Please complete the following to describe Your Past Medical History. This can include any previously diagnosed and/ or treated and resolved problems you may have had in the past.

CONDITIONS					
✓	Check all that apply:	✓	Check all that apply:	✓	Check all that apply:
	Auto-Immune Disease		Coronary Artery Disease		High/ Low Blood Pressure
	Atrial Fibrillation/ Flutter		Coronary Bypass		High Cholesterol/Triglycerides
	Asthma		Convulsions / Seizures		Kidney Disease
	Anxiety/Depression		Diabetes: Type: ____________		Problems w/ Circulation in Leg(s)
	Blood Clots		Emphysema/COPD		Liver Disease
	Cancer (kind)________		Heart Attack / Cardiac Arrest		Rheumatic Fever
	Carotid Stenosis		Heart Murmur		Thyroid Disease
	Congestive Heart Failure		Heart Valve Disease		TIA / Strokes

DRUG ALLERGIES (check if none) ☐ No Known Drug Allergies

List Any Medications that you may be allergic to or have had a reaction to after taking.

SURGICAL HISTORY & HOSPITALIZATIONS (check if none) ☐ No Past Surgeries ☐ No Past Hospital Visits

Surgical History		Hospitalizations	
MM / YYYY	Type of Surgery	MM / YYYY	Reason for Hospital/ ER Visit

Social History (Write 'None' If you have no history of using anything listed below.)

Have you ever used any of the following? If yes, describe frequency, length and quantity of use for each.	
Tobacco	
Caffeine	
Alcohol	
Recreational Drugs	

Signature: ____Date: ____________________

Nadir M. Ali, PLLC

FAMILY HISTORY

Please complete the following to describe the Medical History of your Family Members.

Brother(s) ______	Sister(s) ______	Son(s) ______	Daughter(s) ______

RELATION	Current Age or Age at Death	State of Current Health Deceased or Living?	Cause of Death &/or Health Problems
Mother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			

Indicate If Any of Your Blood Relatives Had Any of the Following:

Disease	Relationship to you	Disease	Relationship to you
Early Death		Heart Disease	
Asthma		High Blood Pressure	
Cancer		Kidney Disease	
Chemical Dependency		Strokes / TIA	
Diabetes		Other	

Medications: **Please list all medications and how they are taken**

Name of Medication & Supplements	Directions of Use

Signature: ____ Date: ________________________

NADIR M ALI, MD PLLC

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281-672-7263

Effective: 09/20/19

RE: Online Consults

Online Consults are cash pay services that are not covered by health insurance. Online consults are **not** intended to establish a provider-patient relationship as our providers are unable to diagnose, treat or prescribe medication without a face-to-face encounter, as mandated by US state licensing regulations. Our healthcare professionals can however discuss online the general approaches to specific health and lifestyle concerns with clients. All communication is private and protected. We maintain a secure record of all communication.

I, ________________________________, agree with the above disclaimer provided by **Nadir M Ali, MD PLLC.** I understand and agree that the office will not file a claim to my insurance on my behalf. I also understand that at this time I will not be able to file a claim on my own to my insurance for reimbursement.

X__________________________________ ________________________
Signature Date