Office of Sally Kashani Medical History Form

Date:_____

Date of Birth:_____ Sex: Male Height:_____ Weight:_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health?..... Yes
2. Has there been any change in your health in the past year?..... Yes
3. My last physical exam was on:_____
4. Are you under the care of another physician?..... Yes
   If so, for what condition?_____
5. The name and address of my physician is: _____
   _____
   _____

Please include any MEDICATIONS you may be taking including homeopathic or natural vitamins:

_____

_____

6. Have you had any serious illness, significant operation or hospitalization with the past 5 years?..... Yes
7. Do you have or have had any of the following diseases or problems:
   a) Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart conditions?..... Yes
      1. Chest pain upon exertion?..... Yes
      2. Shortness of breath after mild exercise?..... Yes
      3. Do your ankles swell?..... Yes
   d) Allergies..... Yes
   e) Asthma..... Yes
   f) Diabetes..... Yes
   g) Frequent or recurring mouth sores..... Yes
   h) Stomach ulcer or hyperacidity..... Yes
   i) Kidney trouble..... Yes
   j) Cancer..... Yes
   k) Sinus trouble..... Yes
   l) Fainting spells or seizures..... Yes
   m) Hepatitis, jaundice or liver disease..... Yes
   n) Thyroid disease..... Yes
   o) Tuberculosis..... Yes
   p) Low blood pressure..... Yes
   q) Persistent swollen neck glands..... Yes
   r) Respiratory problems, emphysema, bronchitis, etc..... Yes
   s) Arthritis..... Yes
   t) Persistent cough or cough that produces blood..... Yes
   u) Epilepsy or neurological disorder..... Yes
   v) Any disease, drug or transplant operation that depressed your immune system..... Yes
   w) Sexually transmitted disease..... Yes
8. Have you had abnormal bleeding?..... Yes
   a) Have you ever required a blood transfusion?..... Yes
9. Do you have any blood disorder such as anemia?..... Yes
10. Are you or have you in the past taken drugs for bone loss: oral or IV, such as FOSAMAX (alendronate), BONIVA, ACTONEL, ZOMETA (zolendronate IV) or any others?..... Yes
11. Have you ever had treatment/radiation for a tumor or growth?..... Yes
12. Are you allergic to or have you had a reaction to:
    a) Penicillin or antibiotics..... Yes
    b) Barbiturates or sleeping pills..... Yes
    c) Local Anesthetics..... Yes
    d) Sulfa drugs..... Yes
    e) Aspirin..... Yes

f) Iodine..... Yes
g) Codeine or other narcotic..... Yes
h) Latex or rubber products..... Yes
i) Other ALLERGIES..... Yes
Please List:_____

13. Have you ever had joint replacement surgery such as KNEE or HIP?..... Yes
When was the surgery? _____
14. Do you wish to talk with the doctor privately about anything?..... Yes
15. Do you have any other condition or disease you think the doctor should know about?..... Yes
Please explain_____

Women

16. Are you pregnant or trying to become pregnant?..... Yes
17. Do you have problems associated with your menstrual period?..... Yes
18. Are you nursing?..... Yes
19. Are you taking birth control pills?..... Yes

IF YOU ARE TAKING ORAL CONTRACEPTIVES IT IS IMPORTANT THAT YOU UNDERSTAND THAT **ANTIBIOTICS AND OTHER MEDICATIONS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES.** THEREFORE YOU WILL NEED TO USE MECHANICAL FORMS OF BIRTH CONTROL FOR ONE COMPLETE CYCLE OF BIRTH CONTROL PILLS FOR AFTER THE COURSE OF ANTIBIOTCS OR OTHER MEDICATIONS IS COMPLETED.
IF YOU ARE PREGNANT OR TRYING TO BECOME PREGNANT, SURGERY, ANESTHETIC OR ANY OTHER MEDICATON MAY SIGNIFIGANTLY HARM YOUR DEVELOPING BABY, ESPECIALLY DURING YOUR FIRST TRIMESTER. PLEASE ADVISE AND TALK TO THE DOCTOR ABOUT ANY CONCERNS OR IF YOU MAY BE PREGNANT.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date:_____ Patient/Guardian Signature:_____

Staff:_____