Dr. Sanaz Khorrami M.D. | Dr. Sean P. Nikravan M.D.

CONFIDENTIAL

Patient Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last physical examination: _____

What is your reason for visit? _____

SYMPTOMS: *Check (✓) conditions you currently have or have had in the past year*

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE / JOINT / BONE
Pain weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hand
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulder

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurry vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period: _____
Date of last Pap Smear: _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

CONDITIONS: *Check (✓) conditions you currently have or have had in the past year*

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heard disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

MEDICATIONS: *List medications you are currently taking*

_____
_____
_____
_____

Pharmacy: _____ Phone: _____

ALLERGIES:

_____
_____
_____
_____
_____

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HEALTH HISTORY

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother				
Sister				

Check (✓) if your blood relatives had any of the following Disease	Relationship to you
☐ Arthritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Tuberculosis	
☐ Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use	
☐ Caffeine	
☐ Tobacco	
☐ Street Drugs	
☐ Other	

Occupational

Check (✓) which you use and how much you use	
☐ Stress	☐ Hazardous Substances
☐ Heavy Lifting	☐ Other
Occupation:	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or personal Representative

Date

Please print name of Patient, Parent, Guardian or personal Representative

Relationship to Patient

Approved By

Date

CLEAR FORM

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