

MEDICAL SURVEY

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PLEASE PRINT

Patient Name: _____ Date: ____/____/____

REASON FOR VISIT: _____

CURRENT MEDICINES: 1. _____ ALLERGIES TO MEDICINES:
2. _____ 3. _____ 1. _____
4. _____ 5. _____ 2. _____
6. _____ 7. _____

PLEASE LIST ALL PRIOR MAJOR ILLNESSES/SURGERIES (WITH YEARS)

Illnesses/Injuries: 1. _____ 2. _____ 3. _____
Hospitalizations: 1. _____ 2. _____ 3. _____
Operations: 1. _____ 2. _____ 3. _____

FAMILY HISTORY: __Heart Disease __Diabetes __Cancer __Sinusitis __Allergies __Other_____

Which family member? _____

Do you drink soda/coffee/tea? __No, never __No, but I used to __Yes ~ Cups/Drinks per day? _____
Do you drink alcohol? __No, never __No, but I used to __Yes ~ How many drinks? ____/day or wk?
Do you smoke? __No, never __No, but I used to __Yes ~ Packs per day? _____x_____ years
Do you use illicit drugs? __No, never __No, but I used to __Yes ~ Which? _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (circle Y or N)

CONSTITUTIONAL weight gain/loss(>15lbs) Y N constant night sweats Y N fatigue Y N
EYES double vision Y N glaucoma Y N
EAR/NOSE/THROAT hearing loss Y N ear pain Y N ringing in ears Y N balance problems Y N hearing aid Y N difficulty breathing Y N nosebleeds Y N nasal drainage Y N sinus problems Y N snoring Y N voice changes Y N
CARDIOVASCULAR heart attack Y N high blood pressure Y N heart murmur Y N
GASTROINTESTINAL diarrhea Y N heartburn Y N
ENDOCRINE diabetes Y N thyroid disease Y N autoimmune disease Y N
NEUROLOGIC headaches Y N seizures Y N stroke Y N
HEMATOLOGY bruise easily Y N anemia Y N excessive bleeding Y N
GENITOURINARY frequent urination Y N prostate problems n/a Y N pain with urination Y N
SKIN past skin cancer Y N past radiation therapy Y N
MUSCULOSKELETAL arthritis Y N back pain Y N
RESPIRATORY asthma/emphysema Y N chronic cough Y N Tuberculosis Y N
PSYCHIATRIC anxiety Y N depression Y N sleep problems Y N
OTHER _____

If YES to any of the above, please explain: _____

Reviewed by: _____, MD