RAJ KANODIA, MD
414 N CAMDEN DR
BEVERLY HILLS, CA 90210

Name: **Age:** **Date:**

Chief Complaint:

Family History: Give age if living or age and cause of death.

Father Mother

Siblings Children

Is there an immediate family history (someone related by blood) of any of the following:

	YES	NO		YES	NO
Heart Trouble			Stroke		
Bleeding Tendency			Keloid Formation		
Diabetes			Cancer		
High Blood Pressure			Other		

ALLERGIES AND SENSITIVITIES: Indicate which, if any are present:

	YES	NO		YES	NO
Penicillin			Aspirin		
Other Antibiotics			Tetanus Toxoid		
Xylocaine			Adhesive Tape		
Codeine			Other		

MEDICATIONS: List all medications you currently take:	**Dosage**	**Frequency**
Cortisone, ACTH, other steroids		
Sedatives, Sleeping Pills, Tranquilizers		
Blood Pressure Regulators		
Digitalis, Nitroglycerine, Cardiac Drugs		
Thyroid		
Aspirin, Coumadin, Heparin		
Birth Control Pills/Hormones		
Appetite Suppressants - including Phen-Fen		
Herbal/Homeopathic		
Other:		

SOCIAL HISTORY

Tobacco: None____ 1 pack/day or less_____ 2 pks/day or more_____

Alcohol: None____ Socially _____ Daily _____

Drugs: None____ Marijuana _____ Cocaine _____ Other _____

RAJ KANODIA, MD
414 N CAMDEN DR
BEVERLY HILLS, CA 90210

SURGICAL HISTORY:

List all prior surgeries, as well as cosmetic (including chemical peels).

Type _____ Date _____ Surgeon _____
Type _____ Date _____ Surgeon _____
Type _____ Date _____ Surgeon _____

Did you experience any problems or complications during or following above procedures?

No _____ Yes_____ Please explain _____

_____

PAST MEDICAL HISTORY: List any prior hospitalizations below (e.g. accidents, surgeries etc.)

Purpose _____ Date _____ Physician _____
Purpose _____ Date _____ Physician _____
Purpose _____ Date _____ Physician _____

Have you recently been under the care of a physician for any particular reason? Yes____

If yes, please explain: _____

Name of Physician _____

Address _____ Telephone _____

REVIEW OF SYSTEMS: Check if any apply:

	Yes	No		Yes	No
Skin Disease			High/Low Blood Pressure		
Eye, Ear, Nose, Throat			Rheumatic Fever		
Thyroid			Anemia, Bleeding Tendencies		
Palpitations			Arthritis		
Diabetes			Liver		
Shortness of Breath			Psychiatric		
Chronic Cough			Tuberculosis		
Asthma			Hepatitis		
Chest Pain, Heart Murmur			HIV		

Is there any history not noted of which the doctor should be aware of? Yes_____ No_____

If yes, please explain: _____

This information is correct and accurate to the best of my knowledge.

Signature of Patient: _____ Date _____

Guardian/Parent: _____ Date _____