

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

PLEASE TAKE NOTE THAT IT IS VERY IMPORTANT THAT THIS SECTION IS COMPLETE:

Current medical
problems:

Medications:

Provide a brief
summary of your
past medical
history and
surgery:

Patient's Name: _____

Date: _____

Patient's Signature: _____

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

Dear Patient,

We thank you for choosing us to participate in your medical care. We take pride in providing world class medical services to individuals and families. Our promise is: "We listen, we care and we follow through." Our offices will care for you with a holistic approach with an awareness of your physical, psychological and emotional needs. Medical care will be tailored to provide prevention, early detection and treatment of illnesses. We will make every attempt to heal each person.

Our office is systematized so the work is done in the same professional manner. You will have a pleasant experience through services delivered with compassion. As a patient, you will be seen on time - every time - as promised by qualified staff. We will offer yearly physical examinations which includes complete history and physical exam, blood test, ECG, stress test and ultrasounds, echo cardiograms, carotid duplex, aortic aneurysm detection, bone density test - all non-invasive, for early detection of illnesses.

Dr. Arman Hekmati is a Board Certified Internist. He completed his education at University of Virginia and Medical College of Virginia and his internship and residency at Los Angeles County University of Southern California Medical Center. He has served as Assistant Professor of Medicine and attending Physician at LAC-USC Medical Center and is currently the President of Foundation for Healthy Living which has been created by him for improving the health and lives of individuals. He has medical staff privileges at St. John's Hospital & Health Center, Cedars-Sinai Medical Center and UCLA Medical Center.

Appointments

Our office is open from 8:30 a.m. to 5:30 p.m. Monday through Friday. Please call during these hours for appointments. If an emergency should arise outside of regular hours, you will be connected to our answering service who will notify Dr. Hekmati or the doctor on-call. If you are unable to keep your appointment, please notify us at least 24 hours before the appointment.

Prescription Refills

Please call your pharmacist and have him fax your prescriptions to our office at 310-275-8727 during office hours to insure prompt service. Please anticipate your needs prior to holidays, evenings, or weekends by having your pharmacist contact our office before. Prescriptions may not be refilled, however, if a patient has failed to keep the follow-up visit. This policy is enforced for the protection of the patient.

Fees, Insurance Billing, and Payment Policies

All services rendered to patients are charged directly to the patient and the patient/ guarantor is personally responsible for payment. We will be happy to file insurance claims within two weeks of visit on your behalf and payment comes directly to you. Certain payments may not be covered within benefits of your insurance. They may include a phone consultation with the patient or family members, consultations with other health care providers, preventive medicine services, individual counseling, physical examinations, injections, family meetings, extra office time, email correspondence and travel time.

All accounts that go beyond 90 days past due will incur interest at the rate of 1.5% per month and transferred to collection for accounts receivable. Should this be necessary, an additional collection fee may be added to your account.

We accept major Credit Cards, Checks and Cash.

Name _____

Date _____

Signature _____

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Last Name _____ First Name _____ MI _____
Home Address _____ City _____ State _____ Zip _____
Phone: Home _____ Work _____ Cell _____
Email Address: _____ Referred by _____
Employer Name & Address _____
Occupation _____ Marital Status: Single Married Widow Divorced
Social Security No. _____ Drivers License No. _____ State _____
Place of Brith _____ DOB _____ Age _____ Sex: M F

In case of an emergency who can we contact

Phone _____ Relationship _____

Primary Ins. Co.

Policy Holder Last Name _____ First Name _____ MI _____
Date of Birth _____ Social Security No. _____
Employer's Name, Address & Phone _____
Policy No. _____ Group No. _____ Relationship _____

Secondary/ Supplemental Ins Co.

Policy Holder Last Name _____ First Name _____ MI _____
Employer's Name, Address & Phone _____
Subscriber No. _____ Group No. _____ Relationship _____

Responsible party for payment

Last Name _____ First Name _____ MI _____
Place of Brith _____ Date of Birth _____ Social Security No. _____
Address _____ City _____ State _____ Zip _____
Phone _____ Work _____ Cell _____
Relationship _____ Drivers Lic. # _____ State _____

I HEREBY AUTHORIZE ARMAN HEKMATI, M.D. TO FURNISH TO MY INSURANCE COMPANY WITH WHICH MY CASE IS INVOLVED, ALL INFORMATION WHICH THE SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY ILLNESS OR INJURY. I UNDERSTAND THAT AS A COURTESY MY PRIMARY INSURANCE AND SUPPLEMENTAL INSURANCE COMPANY WILL BE BILLED FOR MEDICAL AND/ OR HOSPITAL INCURRED EXPENSES. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SAID DOCTOR FOR CHARGES NOT COVERED BY MY INSURANCE AND BILLS ARE DUE UPON RECEIPT. SHOULD SAID BALANCE NOT BE PAID WHEN DUE, LATE CHARGES WILL BE IMPOSED IN THE AMOUNT OF 1 1/2 % INTEREST PER MONTH FROM THE DATE OF MY LAST TREATMENT. IT IS ALSO UNDERSTOOD THAT THE GUARANTOR (IF ANY) AGREES TO REMAIN RESPONSIBLE TO THE SAID DOCTOR FOR ANY AND ALL CHARGES DUE AND OWING. A PHOTOCOPY OF THIS ASSIGNMENT IS AS VALID AS THE ORIGINAL. IN CASE THIS IS SENT FOR COLLECTION I WILL BE RESPONSIBLE FOR A \$20.00 COLLECTION FEE, INTEREST, ATTORNEY, AND COURT COSTS.

Patient's Signature _____ Date _____

Guarantor's Signature _____ Date _____

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires individually identifiable health information used or disclosed by us, whether electronically on paper, or orally, be kept properly confidential. HIPAA gives the patient significant new right to understand and control how health information is used. It also provides penalties for covered entities that misuse personal health information. We may use and disclose your medical records only for the following purposes:

- Treatment Providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment Obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations Conducting quality assessment and improvement activities, auditing cost-management analysis and providing customer service.

We may also create and distribute de-identified health information by removing all individually identifiable information. We may contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits and services, which might of be interest to you. Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization. You have the following rights, which you can exercise by presenting a written request to our office.

- To request restrictions on certain uses and disclosures of protected health information. This include disclosures to family members, other relatives, personal friends, or other persons identified by you. We are not required to agree to requested restrictions. However, if we do agree to a restriction, we are obligated to abide by it unless you agree in writing to remove it.
- To a reasonable request to receive confidential communications from us by alternative means or alternative locations.
- To inspect and copy your protected health information
- To amend your protected health information
- To receive an accounting of disclosures of protected health information
- To obtain a paper copy of this notice upon request

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised Notice of Privacy Practices from this office.

Should you feel your privacy protections have been violated, you may file a written complaint, about violations of the provisions of this notice or of the policies and procedures of our office, with this office or with the Department of Health & Human Services, Office of Civil Rights (address below). We will not retaliate against you for filing a complaint.

Please contact us for more information. For more information about HIPAA contact: The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Ave., SW, Washington, D.C. 20201. PHONE: (202) 619-0257 or toll free (877) 696-6775.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that your office has the right to change its Notice of Privacy Practices from time to time and that I may contact your office at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature and acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Current Date _____ Initial _____

Reason

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

AUTHORIZED TELEPHONE NO. & ADDRESSES AND/ OR INDIVIDUALS FOR RELEASING PATIENT HEALTH INFORMATION

Home No. _____ Work No. _____ Page No. _____
Cell No. _____ Fax No. _____ Email _____
Name _____ Address _____
City _____ State _____ Zip Code _____

PLEASE LIST WHICH INDIVIDUALS YOU ARE AUTHORIZING US TO RELEASE YOUR PERSONAL HEALTH INFORMATION TO:

Name _____ Address _____
City _____ State _____ Zip Code _____ Phone No. _____ Relationship _____
Remark _____

Appointments Medications Medical Care Medical Bill

Name _____ Signature _____ Date _____

HEALTH QUESTIONNAIRE

The purpose of this history form is to give the physician as complete a record as possible of your past health experience. The form should be filled in as completely and carefully as possible. Information which you may think is unimportant may actually be of real value to the physician in diagnosing and following your illness. All information given is confidential.

How long have you felt ill? _____

Since what date? _____

Have you had any fever? Yes No

Have you felt weak? Yes No

Do you have any pain? Yes No

Has there been any loss in weight? Yes No

Has there been any severe chills? Yes No

Have you noted any increase in thirst? Yes No

Are you hard of hearing? Yes No

Have you had frequent severe ear aches? Yes No

Have you had a running ear? Yes No

Do you hear ringing or buzzing in your ears? Yes No

Do you have dizzy spells? Yes No

Has it been more than a year since you last had your eyes checked? Yes No

Do you need glasses for reading or other close work? Yes No

Do you need glasses for seeing things at a distance? Yes No

Has your eyesight ever blacked out completely? Yes No

Do you ever see things double or blurred? Yes No

Do your eyes continually blink or water? Yes No

Do you often see spots before your eyes? Yes No

Are your eyes often red or inflamed? Yes No

Are you colorblind? Yes No

Do you ever have severe pains in or behind your eyes? Yes No

Have you ever had frequent or severe nosebleeds? Yes No

Do you often have heavy chest colds? Yes No

Do you feel a dripping or phelgm in the back of your throat? Yes No

Do you have to clear your throat frequently? Yes No

Do you have frequent sore throats? Yes No

Have you ever been hoarse for more than a month? Yes No

Are you troubled with frequent or severe sneezing spells? Yes No

Is your nose constantly running? Yes No

Have you ever had severe pains in the chest? Yes No

Have you ever had a persistent cough? Yes No

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

- Have you ever coughed up blood? Yes No
- Have you had a chest x-ray within a year/ Yes No
- Did this x-ray show anything wroing in your chest? Yes No
- Did you ever live with anyone who had TB? Yes No
- Do you ever have pains near the heart? Yes No
- Do you ever have a sudden feeling of tightness, burning, or choking in the chest? Yes No
- Are you often conscious of heavy beating of the heart? Yes No
- Does your heart often beat rapidly? Yes No
- Do you ever have difficulty in getting your breath? Yes No
- Do you get out of breath with an ordinary amount of exercise? Yes No
- Do you sometimes get out of breath just sitting still? Yes No
- Are your ankles often swollen? Yes No
- Do your hands or feet feel cold even in hot weather? Yes No
- Do you suffer from frequent painful cramps in your legs? Yes No
- Have your ever noticed varicose (swollen) veins in your legs? Yes No

- How many pillows do you use for sleeping? _____
- Has it been more than a year since you last saw your dentist? Yes No
- Do you have any difficulty chewing? Yes No
- Do you use false teeth or other dentures? Yes No
- Have you ever had bleeding or tender gums? Yes No
- Do you have any sore inside your mouth? Yes No
- Do you often have severe tooth aches? Yes No
- Is your tongue usually badly coated? Yes No
- Do you have any difficulty in swallowing? Yes No
-
- Is your appetite usually poor? Yes No
- Do you often have nausea or upset stomach? Yes No
- Do you eat rapidly? Yes No
- Do you eat between meals? Yes No
- Do you usually feel bloated after eating? Yes No
- Are you often sick to your stomach,with vomiting? Yes No

- Are you awakened at night by stomach pains? Yes No
- Do you have any stomach pains which are relieved by food? Yes No
- Are your meals usually irregular? Yes No
- Do you often have indigestion? Yes No
- Have you ever vomited any blood material? Yes No
- Do severe pains in the stomach ever double you up? Yes No
- Are there any food that you used to eat but that now give you trouble? Yes No

What foods distress you? _____

- How often do you move your bowels daily? _____
- Has there been any recent change in your bowel habits? Yes No
- Do you constantly suffer from severeconstipation? Yes No
- Do you frequent loose bowel movements? Yes No
- Do you strain at stool? Yes No
- Have you noted much mucus in your stool? Yes No
- Are your stools ever thin and pencil shaped? Yes No
- Have you ever had any light clay-colored stools? Yes No
- Have you noted puss in you stools? Yes No
- Have you ever had bloody bowel movements? Yes No
- Have you ever had black or tarry bowel movements? Yes No
- Do you have hemorrhoids? Yes No
- Have you ever had fistula? Yes No
- Do you often take laxatives? Yes No
- What laxatives do you take? Yes No

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

FOOD HISTORY

	TIME	PLACE	USUAL MENU
BREAKFAST			
LUNCH			
SUPPER			

Do you watch your weight carefully?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Have you ever noticed a lump in your breast?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you limit your calorie intake?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Have you ever noticed any discharge from your nipples?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you limit your fat intake?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Have your breasts ever been sore, painful, or swollen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you limit your salt intake?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you have any black moles?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you use the Los Angeles water?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you have frequent severe headaches?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you use carbonated drinks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you often feel miserable from pressure or pain in the head?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have your joints ever been painfully swollen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you have hot or cold spells?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do your muscles and joints always feel stiff?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you often have spells of severe dizziness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you usually have severe pains in the arms or legs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you frequently feel faint?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you crippled with severe rheumatism?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Have you fainted more than twice in your life?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you suffer from weak or painful feet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you ever aware of numbness or tingling in any part of your body?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have pains in the back that make it hard for you to keep up with your daily activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Was an part of your body ever paralyzed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you troubled by a serious bodily disability or deformity?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<hr/>		
Are you troubled by morning stiffness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Have you ever noticed twitching of any part of your body?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your skin unusually dry?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Did you ever have a convulsion (epilepsy)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your skin unusually sweaty?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you ever have to get up at night to pass water?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your skin unusually sensitive or tender?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you usually urinate frequently during the day?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do cuts in your skin usually stay open a long time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you ever have severe burning pain when you urinate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you any sore that don't seem to heal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Have you ever noticed blood in your urine, or passed blood while urinating?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your face often get badly flushed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you have trouble in starting to urinate or in stopping your stream when urinating?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you sweat a great deal even in cold weather?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you sometimes lose control of your bladder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you often bothered by severe itching?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Does your skin often break out in a rash?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Are you subject to frequent boils?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Have you any swollen glands in any part of your body?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Do you have any birthmarks, warts, or moles?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Have you any painless lumps or thickening anywhere on your body?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

Have you ever been bothered by pain in your back or groin?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you often shake or tremble?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you often have small accidents or injuries?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you often awakened out of your sleep by frightening dreams?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had any recent loss of memory?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do frightening thoughts keep coming back in your mind?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you bite your nails?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you often become suddenly frightened for no good reason?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you pull off your nails?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you often break out in a cold sweat?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you stutter?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does every little effort wear you out?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you sweat or tremble a lot during examinations or questioning?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you constantly too tired and exhausted even to eat?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you get nervous and shaky if anyone is watching you?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you suffer from severe nervous exhaustion?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you make frequent mistakes when you do things quickly?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you considered a sickly person?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you often get directions and orders wrong?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you frequently confined to bed by illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do strange people or places make you afraid?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you come from a sickly family?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you afraid to be alone when there are no friends near you?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do severe pains and aches make it impossible for you to carry on you daily activities?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you considered a clumsy person?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you usually feel unhappy and depressed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<u>FOR WOMEN</u>	
Do you often cry?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of pregnancies?	_____
Does life look entirely hopeless?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of miscarriages?	_____
Do you grind your teeth a good deal?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have any sexual problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you find yourself sighting a great deal?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are your menstrual periods irregular?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your home life unsatisfactory?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have your menstrual periods usually been painful?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you often wish you were dead and away from it all?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you often felt weak or sick with your periods, so that you had to lie down?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does worrying continually get you down?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you usually tense or jumpy with your period?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does worrying run in your family?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you bleed excessively or pass clots of blood with your periods?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you considered a nervous person?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had severe hot flashes or sweats?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you extremely shy or sensitive?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you often had vaginal discharge?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are your feelings easily hurt?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever noticed any spotting with blood or bleeding between periods?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does criticism upset you?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you had the change of life?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do people usually misunderstand you?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you always do things on sudden impulse?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Are you easily upset or irritated?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do people often annoy and irritate you?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you flare up in anger if you can't have what you want right away?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you often get into a violent rage?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

FOR WOMEN

Have you had any bleeding or discharge since the change of life? Yes No

How old were you when you began to menstruate? _____

How often do you menstruate? _____

How long do your periods last? _____

When was your last menstrual period? _____

Do you have premenstrual tension? _____

Are you on contraceptive pills? Yes No

FOR MEN

Have you ever had anything wrong with your genitals (privates?) Yes No

Are your genitals often painful or sore? Yes No

Have you ever had a discharge from your genitals? Yes No

Have you ever received treatment for any genital trouble? Yes No

Have you been treated for a venereal disease? Yes No

Do you have any sexual problems? Yes No

Have you ever had any of the following operations or accidents and at what age?

Tonsils _____ Exploratory _____

Adenoids _____ Hernia _____

Ears Lanced _____ Thyroid _____

Mastoid _____ Breast Lump _____

Sinus _____ Removal of Uterus _____

Nasal _____ Removal of Ovary _____

Carbuncle _____ Tying of Uterus _____

Burns _____ Curettage _____

Scalds _____ Abortions _____

Poisoning _____ Removal of Prostate _____

Injuries _____ Removal of Testicle _____

Fractures _____ Hemorrhoids _____

Appendix _____ Varicose Veins _____

Gall Bladder _____ Kidney Trouble _____

Syphilis _____ Kidney Stones _____

Gonorrhea _____ Bladder Trouble _____

Brucellosis (Malta Fever) _____ Kidney Stones _____

Typhoid _____ Bladder Trouble _____

Typhus _____ Prostate Trouble _____

Dysentery _____ Liver Trouble _____

Boils _____ Gall Bladder Trouble _____

Fever of Unknown Origin _____ Heart Stones _____

Tetanus _____ Arthritis _____

Cholera _____ Thyroid Trouble _____

Pyelitis _____ Bronchiectasis _____

Furunculosis _____ Erysipelas _____

Have you ever had any of the following diseases and what age?

Measles _____ Scarlet Fever _____

Mumps _____ Septicemia _____

Smallpox _____ Osteomyelitis _____

Chicken Pox _____ Repeated Sore Throats _____

Whooping Cough _____ Sinusitis _____

Colds _____ Abscessed Ear _____

How many? _____ Mastoid _____

Influenza _____ Bronchitis _____

Jaundice _____ Pleurisy _____

Cancer _____ Pneumonia _____

Yellow Fever _____ Tuberculosis _____

Poliomyelitis _____ High Blood Pressure _____

Meningitis _____ Low Blood Pressure _____

Contact with a person w/ TB _____ Anemia _____

Diphtheria _____ Amoeba _____

Varicose Veins _____ Intestinal Parasites _____

Phlebitis _____ Malaria _____

Hemorrhoids _____ Diabetes _____

Hernia _____

When were you last immunized against any of the following disease?

Smallpox _____ Typhus _____

Typhoid _____ Diphtheria _____

Tetanus _____ Influenza _____

Polio _____ Salk or Sabin _____

Yellow Fever _____ Measles _____

Cholera _____ Rabies _____

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

Family History

Whom do you resemble physically? _____ Rheumatic Fever Yes No Hemophilia Yes No

Has anyone in your family had trouble similar to yours Yes No High Blood Pressure Yes No Glaucoma Yes No

Has anyone in your family had any of the following disease: Yes No Heart Trouble Yes No Obesity Yes No

Cancer Yes No Nervous Breakdown Yes No Stomach Trouble Yes No Gout Yes No

Tuberculosis Yes No Asthma Yes No Anemia Yes No Nephritis (Kidney Trouble) Yes No

Severe Headaches Yes No Eczema Yes No Cataract Yes No Goiter Yes No

Epilepsy Yes No Hay Fever Yes No Diabetes Yes No

Mental Disease Yes No Other Allergies Yes No Color Blindness Yes No

	FATHER	MOTHER	SIBLINGS	MATE	CHILDREN
LIVING					
DEAD					
ILLNESS					

PERSONAL HISTORY

Sleep Yes No Do you regularly use sedatives for sleep? Yes No

Do you breathe through your mouth when asleep? Yes No Are you tired in the morning? Yes No

Are your sleeping habits irregular? Yes No Do you take a nap? Yes No

Is your sleep disturbed? Yes No Do you usually have a great difficulty in falling asleep or staying asleep? Yes No

Do you take tranquilizers? Yes No Do you take pep-up pills? Yes No

WORK

What time do you start work? _____

What time do you finish work? _____

How long do you take for lunch? _____

How many days a week do you work? _____

When did you have your last vacation? _____

How long was it? _____

ALCOHOL

How much beer do you drink daily? _____

How much wine do you drink daily? _____

How many highballs or cocktails daily? _____

Do you go on alcoholic binges? _____

Do you drink in the mornings? _____

SMOKING

Do you use filter holder? _____

Do you chew tobacco? _____

Do you use snuff? _____

If you smoke, would you stop? _____

If you had quit smoking, when did you quit? _____

EXERCISE

Do you take any regular exercise? _____

What type of exercise? _____

Any further comments? _____

INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

MEDICAL RECORDS RELEASE FORM

DATE: _____

TO: _____

Doctor or Hospital

Department

Street Address

Suite Number

City

State

Zip Code

Telephone Number

Fax Number

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE

TO: ARMAN HEKMATI, M.D.

Doctor or Hospital

Department

9675 BRIGHTON WAY

SUITE 380

Street Address

Suite Number

BEVERLY HILLS

CA

90210

City

State

Zip Code

THE COMPLETE MEDICAL RECORDS, INCLUDING X-RAY FILMS, IN YOUR POSSESSION CONCERNING MY ILLNESS AND/ OR TREATMENT DURING THE PERIOD FROM:

_____ **TO** _____

COMMENTS: _____

SIGNED: _____

Patient or Nearest Relative

RELATIONSHIP: _____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT'S SOCIAL SECURITY NO _____

PATIENT'S MED. RECORDS NO. _____