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: _____

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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 _____

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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 _____

Subcriber 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 INSURACE 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 WLL BE IMPOSED IN THE AMOUNT OF 1 1/2 % INTEREST PER MONTH FROM THE ATE OF MY LAST TREATMEN. 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 _____

Guaranator's Signature _____ Date _____

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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 (HIPPA), 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 usesand 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

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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 ☐

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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 ☐

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FOOD HISTORY

	TIME	PLACE	USUAL MENU
BREAKFAST			
LUNCH			
SUPPER			

Do you watch your weight carefully? Yes ☐ No ☐

Do you limit your calorie intake? Yes ☐ No ☐

Do you limit your fat inatake? Yes ☐ No ☐

Do you limit your salt intake? Yes ☐ No ☐

Do you use the Los Angeles water? Yes ☐ No ☐

Do you use carbonated drinks? Yes ☐ No ☐

Have your joints ever been painfully swollen? Yes ☐ No ☐

Do your muscles and joints always feel stiff? Yes ☐ No ☐

Do you usually have severe pains in the arms or legs? Yes ☐ No ☐

Are you crippled with severe rheumatism? Yes ☐ No ☐

Do you suffer from weak or painful feet? Yes ☐ No ☐

Do you have pains in the back that make it hard for you to keep uo with your daily activities? Yes ☐ No ☐

Are you troubled by a serious bodily disability or deformity? Yes ☐ No ☐

Are you troubled by morning stiffness? Yes ☐ No ☐

Is your skin unusually dry? Yes ☐ No ☐

Is your skin unusually sweaty? Yes ☐ No ☐

Is your skin unusually sensitive or tender? Yes ☐ No ☐

Do cuts in your skin usually stay open a long time? Yes ☐ No ☐

Have you any sore that don't seem to heal? Yes ☐ No ☐

Does your face often get badly flushed? Yes ☐ No ☐

Do you sweat a great deal even in cold weather? Yes ☐ No ☐

Are you often bothered by severe itching? Yes ☐ No ☐

Does your skin often break out in a rash? Yes ☐ No ☐

Are you subject to frequent boils? Yes ☐ No ☐

Have you any swollen glands in any part of your body? Yes ☐ No ☐

Do you have any birthmarks, warts, or moles? Yes ☐ No ☐

Have you any painless lumps or thickening anywhere on your body? Yes ☐ No ☐

Have you ever noticed a lump in your breast? Yes ☐ No ☐

Have you ever noticed any discharge from your nipples? Yes ☐ No ☐

Have your breasts ever been sore, painful, or swollen? Yes ☐ No ☐

Do you have any black moles? Yes ☐ No ☐

Do you have frequent severe headaches? Yes ☐ No ☐

Do you often feel miserable from pressure or pain in the head? Yes ☐ No ☐

Do you have hot or cold spells? Yes ☐ No ☐

Do you often have spells of severe dizzines? Yes ☐ No ☐

Do you frequently feel faint? Yes ☐ No ☐

Have you fainted more than twice in your life? Yes ☐ No ☐

Are you ever aware of numbness or tingling in any part of your body? Yes ☐ No ☐

Was an part of your body ever paralyzed? Yes ☐ No ☐

Have you ever noticed twitching of any part of your body? Yes ☐ No ☐

Did you ever have a convulsion (epilepsy)? Yes ☐ No ☐

Do you ever have to get up at night to pass water? Yes ☐ No ☐

Do you usually urinate frequently during the day? Yes ☐ No ☐

Do you ever have severe burning pain when you urinate? Yes ☐ No ☐

Have you ever noticed blood in your urine, or passed blood while urinating? Yes ☐ No ☐

Do you have trouble in starting to urinate or in stopping your stream when urinating? Yes ☐ No ☐

Do you sometimes lose control of your bladder? Yes ☐ No ☐

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Have you ever been bothered by pain in your back or groin? Yes ☐ No ☐

Do you often have small accidents or injuries? Yes ☐ No ☐

Have you had any recent loss of memory? Yes ☐ No ☐

Do you bite your nails? Yes ☐ No ☐

Do you pull off your nails? Yes ☐ No ☐

Do you stutter? Yes ☐ No ☐

Do you sweat or tremble a lot during examinations or questioning? Yes ☐ No ☐

Do you get nervous and shaky if anyone is watching you? Yes ☐ No ☐

Do you make frequent mistakes when you do things quickly? Yes ☐ No ☐

Do you often get directions and orders wrong? Yes ☐ No ☐

Do strange people or places make you afraid? Yes ☐ No ☐

Are you afraid to be alone when there are no friends near you? Yes ☐ No ☐

Are you considered a clumsy person? Yes ☐ No ☐

Do you usually feel unhappy and depressed? Yes ☐ No ☐

Do you often cry? Yes ☐ No ☐

Does life look entirely hopeless? Yes ☐ No ☐

Do you grind your teeth a good deal? Yes ☐ No ☐

Do you find yourself sighting a great deal? Yes ☐ No ☐

Is your home life unsatisfactory? Yes ☐ No ☐

Do you often wish you were dead and away from it all? Yes ☐ No ☐

Does worrying continually get you down? Yes ☐ No ☐

Does worrying run in your family? Yes ☐ No ☐

Are you considered a nervous person? Yes ☐ No ☐

Are you extremely shy or sensitive? Yes ☐ No ☐

Are your feelings easily hurt? Yes ☐ No ☐

Does criticism upset you? Yes ☐ No ☐

Do people usually misunderstand you? Yes ☐ No ☐

Do you always do things on sudden impulse? Yes ☐ No ☐

Are you easily upset or irritated? Yes ☐ No ☐

Do people often annoy and irritate you? Yes ☐ No ☐

Do you flare up in anger if you can't have what you want right away? Yes ☐ No ☐

Do you often get into a violent rage? Yes ☐ No ☐

Do you often shake or tremble? Yes ☐ No ☐

Are you often awakened out of your sleep by frightening dreams? Yes ☐ No ☐

Do frightening thoughts keep coming back in your mind? Yes ☐ No ☐

Do you often become suddenly frightened for no good reason? Yes ☐ No ☐

Do you often break out in a cold sweat? Yes ☐ No ☐

Does every little effort wear you out? Yes ☐ No ☐

Are you constantly too tired and exhausted even to eat? Yes ☐ No ☐

Do you suffer from severe nervous exhaustion? Yes ☐ No ☐

Are you considered a sickly person? Yes ☐ No ☐

Are you frequently confined to bed by illness? Yes ☐ No ☐

Do you come from a sickly family? Yes ☐ No ☐

Do severe pains and aches make it impossible for you to carry on you daily activities? Yes ☐ No ☐

FOR WOMEN

Number of pregnancies? _____

Number of miscarriages? _____

Do you have any sexual problems? Yes ☐ No ☐

Are your menstrual periods irregular? Yes ☐ No ☐

Have your menstrual periods usually been painful? Yes ☐ No ☐

Have you often felt weak or sick with your periods, so that you had to lie down? Yes ☐ No ☐

Are you usually tense or jumpy with your period? Yes ☐ No ☐

Do you bleed excessively or pass clots of blood with your periods? Yes ☐ No ☐

Have you ever had severe hot flashes or sweats? Yes ☐ No ☐

Have you often had vaginal discharge? Yes ☐ No ☐

Have you ever noticed any spotting with blood or bleeding between periods? Yes ☐ No ☐

Have you had the change of life? Yes ☐ No ☐

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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	_____
Syphillis	_____	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	_____
Furnculosis	_____	Erysipelas	_____

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

Measles	_____	Scarlet Fever	_____
Mumps	_____		
Smallpox	_____	Septicemia	_____
Chicken Pox	_____	Osteomyelitis	_____
Whooping Cough	_____	Repeated Sore Throats	_____
Colds	_____	Sinusitis	_____
How many?	_____	Abscessed Ear	_____
Influenza	_____	Mastoid	_____
Jaundice	_____	Bronchitis	_____
Cancer	_____	Pleurisy	_____
Yellow Fever	_____	Pneumonia	_____
Poliomyelitis	_____	Tuberculosis	_____
Meningitis	_____	High Blood Pressure	_____
Contact with a person w/ TB	_____	Low Blood Pressure	_____
Diphteria	_____	Anemia	_____
Varicose Veins	_____	Amoeba	_____
Phlebitis	_____	Intestinal Parasites	_____
Hemorrhoids	_____	Malaria	_____
Hernia	_____	Diabetes	_____

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

Smallpox	_____	Typhus	_____
Typhoid	_____	Diphteria	_____
Tetanus	_____	Influenza	_____
Polio	_____	Salk or Sabin	_____
Yellow Fever	_____	Measles	_____
Cholera	_____	Rabies	_____

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Family History

Whom do you resemble physically?

Has anyone in your family had trouble similar to yours Yes ☐ No☐

Has anyone in your family had any of the following disease: Yes ☐ No☐

Cancer Yes ☐ No☐

Tuberculosis Yes☐ No☐

Severe Headaches Yes ☐ No☐

Epilepsy Yes ☐ No☐

Mental Disease Yes ☐ No☐

Nervous Breakdown Yes ☐ No☐

Asthma Yes ☐ No☐

Eczema Yes ☐ No☐

Hay Fever Yes ☐ No☐

Other Allergies Yes ☐ No☐

Rheumatic Fever Yes ☐ No☐

High Blood Pressure Yes ☐ No☐

Heart Trouble Yes ☐ No☐

Stomach Trouble Yes ☐ No☐

Anemia Yes ☐ No☐

Cataract Yes ☐ No☐

Diabetes Yes ☐ No☐

Color Blindness Yes ☐ No☐

Hemophilia Yes ☐ No☐

Glaucoma Yes ☐ No☐

Obesity Yes ☐ No☐

Gout Yes ☐ No☐

Nephritis (Kidney Trouble Yes ☐ No☐

Goiter Yes ☐ No☐

	FATHER	MOTHER	SIBLINGS	MATE	CHILDREN
LIVING					
DEAD					
ILLNESS					

PERSONAL HISTORY

Sleep Yes ☐ No☐

Do you breathe through your mouth when asleep? Yes ☐ No☐

Are your sleeping habits irregular? Yes ☐ No☐

Is your sleep disturbed? Yes ☐ No☐

Do you take tranquilizers? Yes☐ No☐

Do you regurlarly use sedatives for sleep? Yes ☐ No☐

Are you tired in the morning? Yes ☐ No☐

Do you take a nap? Yes ☐ No☐

Do you usually have a great difficulty in falling asleep or staying asleep? 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. _____