

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 \_\_\_\_\_

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**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 \_\_\_\_\_