Ramin Mehdian, M.D F.C.C. P
1000 Newbury Rd, Suite 275
Newbury Park, CA 91320

Patients name: _____ Date: _____
Referred by: _____

Please briefly fill out the following information

A. Reason for visit: _____
_____

B. List of medications(please include dosage and frequency of usage):
_____
_____
_____
_____
_____
_____

C. Allergies to medications (include what type of allergic reaction to the med):
_____
_____
_____

D. Past medical history: (please mark yes or no)

HEENT

Glaucoma/ Cataract/ Other eye disorder _____[ ] Yes [ ] No
Chronic sinusitis_____[ ] Yes [ ] No
Environmental allergies_____[ ] Yes [ ] No
Post-nasal drip_____[ ] Yes [ ] No
Nasal polyps_____[ ] Yes [ ] No
Deviated septum _____[ ] Yes [ ] No
Stroke/Transient ischemic attack _____[ ] Yes [ ] No
Seizure disorder_____[ ] Yes [ ] No
Headaches/ Migraines _____ [ ] Yes [ ] No

Endocrine problems

Diabetes mellitus _____[ ] Yes [ ] No
Overactive thyroid/Hyperthyroidism_____ [ ] Yes [ ] No
Underactive thyroid/Hypothyroidism_____[ ] Yes [ ] No
Thyroid mass_____[ ] Yes [ ] No

Cardiovascular problems

Heart disease/heart attack_____ [ ] Yes [ ] No
Murmur _____[ ] Yes [ ] No
Hypertension _____[ ] Yes [ ] No
High cholesterol/Hyperlipidemia_____[ ] Yes [ ] No
Bleeding disorder_____[ ] Yes [ ] No

Lung problems

Asthma _____[ ] Yes [ ] No
Emphysema_____[ ] Yes [ ] No
Collapsed lung_____[ ] Yes [ ] No
Lung tumor _____[ ] Yes [ ] No
Blood clots in the lung_____[ ] Yes [ ] No
Sarcoidosis_____[ ] Yes [ ] No
Tuberculosis_____[ ] Yes [ ]No
Sleep Apnea _____[ ] Yes [ ]No

Gastrointestinal problems

Acid reflux/ GERD _____[ ] Yes [ ] No
Ulcers_____[ ] Yes [ ] No
Gastritis _____[ ] Yes [ ] No
Colitis_____[ ] Yes [ ] No
Diverticular disease_____[ ] Yes [ ] No
Hemorrhoids _____[ ] Yes [ ] No
Liver disease_____[ ] Yes [ ] No
Hepatitis_____[ ] Yes [ ] No
Irritable bowel syndrome_____[ ] Yes [ ] No
Pancreatic disorder _____[ ] Yes [ ] No

Genitourinary problems

Prostate disorder_____[ ] Yes [ ] No
Gynecologic disorder_____[ ] Yes [ ] No
Kidney disorder _____[ ] Yes [ ] No

Connective tissue problems

Rheumatoid arthritis_____[ ] Yes [ ] No
Lupus_____ [ ] Yes [ ] No
Sjogren's disease_____[ ] Yes [ ] No
Scleroderma _____[ ] Yes [ ] No
Osteoporosis_____ [ ] Yes [ ] No
Psoriasis_____[ ] Yes [ ] No
Gout_____[ ] Yes [ ] No
Amyloidosis _____[ ] Yes [ ] No

General

Blood clots _____[ ] Yes [ ] No
Bone, joint, muscle disorder _____[ ] Yes [ ] No
Recurrent infections_____[ ] Yes [ ] No
Tumors or malignancies_____[ ] Yes [ ] No
Anemia _____[ ] Yes [ ] No
Leukemia _____ [ ] Yes [ ] No
Lymphoma_____[ ] Yes [ ] No
HIV_____[ ] Yes [ ] No

E. Surgical History (list all surgeries you have had in the past):

_____
_____
_____
_____

F. Family history (list their medical problems)

Father:_____
Mother: _____
Brothers: _____
Sisters: _____
Sons: _____
Daughters: _____

G. Social history:

Tobacco use (**past or present**)_____ [ ] Yes [ ] No
If yes: Number packs per day _____
Number of years_____
Quit date_____
Alcohol use (**past or present**) _____[ ] Yes [ ] No
If yes: Number of years_____
Number of drinks_____
Socially [ ] Weekends[ ] Weekdays [ ]
Recreational drugs (**past or present**) _____[ ] Yes [ ] No
Recent travel history: _____
_____

Previous occupations: _____

REVIEW OF SYSTEMS: Circle those items that presently apply to you.

GENERAL:
- Fever
- Chills
- Night sweats
- Weight loss
- Weight gain
- Heat intolerance
- Cold intolerance

HEENT:
- Throat drainage
- Throat pain
- Sinus pressure
- Headaches
- Sinus congestion

NEUROLOGIC:
- Numbness
- Tingling in extremities
- Weakness
- Dizziness

RESPIRATORY:
- Cough
- Coughing up blood
- Shortness of breath
- Shortness of breath with exertion
- Chest Pain
- Chest tightness
- Wheezes
- Environmental exposure to chemical/toxins
- Occupational exposure to chemicals/toxins
- Post nasal drip

CARDIAC:
- Chest pain
- Palpitations
- Chest tightness
- Ankle swelling

SKIN:
- Rash
- Change in moles
- Discoloration
- Easy bruising
- Prolonged bleeding

GASTROENTEROLOGIC:
- Difficulty swallowing/choking
- Pain with swallowing
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Blood in stool
- Change in bowel habits
- Change in stool size
- GERD/Acid reflux
- Regurgitation

UROLOGIC:
- Urinary frequency
- Urinary urgency
- Difficulty starting or stopping urinary
- Incontinence
- Blood in urine

SLEEP:
- Daytime sleepiness
- Snoring
- Witness apneas (Pause in breathing while asleep)
- Sleep paralysis
- Vivid dreaming or hallucinations in bed
- Periodic limb movement in sleep
- Restless leg syndrome
- Insomnia

RAMIN MEHDIAN, M.D.

Pulmonary and Critical Care Medicine
Internal Medicine/Sleep Disorders

PATIENT INFORMATION

NAME _____ **( )** MALE **( )** FEMALE
(LAST) (FIRST) (MI)

ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP _____

HOME PHONE **( )**_____ CELL PHONE **( )** _____ **Email:** _____

OCCUPATION _____ EMPLOYED BY _____

DATE OF BIRTH ____/____/____ AGE _____ SOCIAL SEC # _____

SPOUSE NAME _____ WORK PHONE # **( )**_____

EMERGENCY CONTACT _____ PHONE **( )**_____

REFERRED BY _____

****

Health Insurance Information

please Complete This Section and Give the Secretary Your Insurance Cards to Photocopy

PRIMARY INSURANCE CO. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PH# **( )**_____

ID/CERT# _____ GROUP POLICY # _____

SUBSCRIBER _____ SUBSCRIBER DOB ____/____/____ SOC SEC# _____

SECONDARY/ SUPPLEMENTAL INSURANCE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

ID/CERT# _____ GROUP POLICY # _____

SUBSCRIBER _____ SUBSCRIBER DOB ____/____/____ SOC SEC# _____

ASSIGNMENT AUTHORIZATION: I hereby authorize Provider to provide medical care and direct my insurance carrier to pay directly to this provide any benefits due to me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I further authorize this provider to release to my insurance company any medical information necessary to process this claim. If I am uninsured, I am fully responsible for all charges.

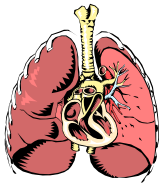
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE _____

INDIVIDUAL PATIENT'S AUTHORIZATION: I hereby authorize and confirm my authorization for use/disclosure of the protected health information to other physicians and/or organization and/or insurance companies for purpose of medical treatment and consultation.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE _____ Date _____

Ramin Mehdian, M.D.

Pulmonary- Critical Care
Internal Medicine and Sleep Disorders



HIPPA 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. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this practice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by calling (805)499-4143.
This notice was published and becomes effective on **April 14,2003.**

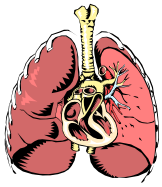
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please call (805)499-4143.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Signature _____ **Date** _____

Relationship to Patient _____

Ramin Mehdian, M.D.
Pulmonary- Critical Care
Internal Medicine and Sleep Disorders



Dear Patients,

As a courtesy to our staff and other patients in our practice, we ask that you cancel or reschedule your appointments 24 hours ahead of time. We reserve the right to charge for a full office visit for no show or if an appointment has not been rescheduled or cancelled 24 hours ahead of time.

Thank you

Dr. Ramin Mehdian

Patient's Signature **Date**