PLEASE PRINT THIS PAGE FILL AND FAX TO CLINIC AT FAX: (702) 933-6770

FARRUKH IMTIAZ, M.D.

MEDICAL HISTORY

Patient Name: _____ Date: _____
Birthplace:_____ Hobbies: _____

HABITS

Do you smoke? No ___ Yes ___ How long? _____ How much? _____
Do you drink alcoholic beverages? No ___ Yes ___ How long?_____ Frequency? _____
Do you take recreational drugs? No ___ Yes ___ What? _____ Frequency? _____

PAST MEDICAL HISTORY (Check all that apply)

Ailment	Self	Family	Ailment	Self	Family
Heart Trouble	___	___	Cancer	___	___
Diabetes	___	___	Emphysema	___	___
Liver Disease	___	___	Stroke	___	___
Multiple Sclerosis	___	___	Thyroid Troub le	___	___
Hypertension	___	___	HIV/AIDS	___	___
Epilepsy/Seizures	___	___	Anemia	___	___
Kidney Trouble ___	___		Phlebitis/Vericose Veins	___	___
Asthma/Allergies	___	___	Gall Bladder	___	___
Bowel Disorders	___	___	Glaucoma/Cataracts	___	___

When was your last Tetanus Shot? _____ Are you interested in yearly flu shots? ____
Have you had pneumonia? _____

SURGICAL PROCEDURES	DATES
_____	_____
_____	_____
_____	_____

MEDICATION ALLERGIES	REACTIONS
_____	_____
_____	_____

Do you suffer from any of the following? (Check all that apply)

Dizziness/Weakness___	Insomnia___	Weight loss/gain	___
Anxiety___	Eye Trouble___	Shortness of Breath	___
Hemorrhoids___	Coughing___	Headaches	___
Frequent Indigestion___	Arthritis___	Blood in Stool	___
Chronic Back Pain___	Neck Pain___	Chest Pain	___
Abdominal Pain___	STD___	Coughing Blood	___
Frequent Indigestion___	Diarrhea___	Constipation	___

Any additional _____

CURRENT MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any concerns about your health which are not mentioned above?

_____
_____
_____
_____