**KHOSROW MAHDAVI, M.D., INC\***

**HOAG Health Facility**

**520 Superior Ave., Suite 315**

**NEWPORT BEACH, CALIFORNIA 92663**

**PHONE 949-642-8566 FAX 866-235-0746**

**KHOSROW MAHDAVI, M.D., FACP**

**BOARD CERTIFIED INTERNAL MEDICINE**

**BOARD CERTITIED MEDICAL ONCOLOGY**

**BOARD CERTIFIED HEMATOLOGY**

**\*Affiliated with NDMG,INC**

**PLEASE BE SURE TO ANSWER ALL THE FOLLOWING QUESTIONS. *THANK YOU***

**Patient history sheet (please print)**

**PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU CURRENTLY A SMOKER YES OR NO**

**IF YES, HOW LONG HAVE YOU SMOKED?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF NO DO YOU HAVE A HISTORY OF SMOKING? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LIST YOUR CURRENT ORAL MEDICATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

**DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? (PLEASE STATE NONE IF YOU HAVE NONE, AND IF YOU DO PLEASE LIST THE MEDICATIONS)**

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

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