Dr. Ali Tehrani
18064 Wika Road, Suite 103, Apple Valley, CA 92307
Phone: (760) 240-2444 · Fax: (760) 240-5554
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PATIENT MEDICAL HISTORY

☐ Mrs. ☐ Ms. ☐ Mr. ☐ Miss	Patient's Last Name:	First:	Middle:	Today's Date

Age:	Birth Date:	Height:	Weight:
	/ /		

Why Are You Seeing The Doctor Today?

Do You Have Or Have You Had:

Yes	No		Yes	No	
		A reaction to local or general anesthesia			Do you smoke cigarettes?
		Asthma			Do you drink more than 2 ounces of alcohol a day?
		Hay Fever			Do you drink more than 6 cups of coffee a day?
		Problems with your eyes or vision			Received treatment for abuse of alcohol or drugs?
		Heart trouble			Do you get depressed?
		Stomach trouble or ulcers			Thyroid disease
		Chest or lung problems			Nervous breakdown
		Yellow, jaundice, liver or gallbladder trouble			Received medication for a nervous condition
		Kidney or bladder problems			Are you easily upset?
		Excessive bleeding			Do you hold a grudge when someone angers you?
		Anemia or blood problems			Have you been treated by a psychiatrist?
		Poor circulation			Blood clots in your lungs or legs
		Frequent skin infections			Prostate problems
		Severe headaches or dizziness			Immune disorder or AIDS
		Paralysis or numbness			Poor healing
		Convulsions or seizures			High blood pressure
		Diabetes			Fever blisters or cold sores in your mouth or genital areas
		Date of Last Mammogram			Lumps in your breast

List any medications you are taking, including non-prescription, vitamins and herbals: ______________________

List any allergies: ______________________

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List previous surgical procedures and hospitalizations along with the date: ____________________

____

Do you accept the fact that every medical and surgical treatment is associated with risks and unforeseen occurrences? ☐ Yes ☐ No
The above is true and correct to the best of my knowledge.

______________________________ ______________

Patient/Guardian Signature Date