NATURAL MEDICAL CARE

Dr. Mehdi L. Khosh, ND
Building 22, Suite 2200
10875 Grandview Drive
Overland Park, KS 66210
(913) 345-0060

Dr. Farhang R. Khosh, ND
Dr. Mehdi L. Khosh, ND
4935 Research Park Way
Lawrence, KS 66047
(785) 749-2255

I. Patient Information

Patient Name (Last, First, Middle Initial) ____________________

Parent or Legal Guardian (if a minor) ____________________

Address ____________________

Birth date ____________________ Patient SS # ____________________

Sex: M or F Single__ Married __ Widowed __ Separated __ Divorced __

Home Phone ____________________ Work Phone ____________________ Ext. ____ Mobile ____________________

When is the best time to reach you? ____________________ Email Address ____________________

Occupation ____________________ Employer/School ____________________

Employer/School Address ____________________

Email Address ____________________

Whom may we thank for referring you? ____________________

II. Spousal Information

Spouse Name ____________________

Spouse Birth date ____________________ Spouse SS # ____________________

Spouse Occupation ____________________ Spouse Employer ____________________

III. In Case of Emergency

Name ____________________ Relationship ____________________

Home Phone ____________________ Work Phone ____________________ Mobile ____________________

IV. Responsible Party

Who is responsible for this account (if other than patient)? ____________________

Relationship to Patient ____________________ Responsible Party SS# ____________________

Responsible Party Home Phone ____________________ Work Phone ____________________ Ext ________

I understand that I am financially responsible for all charges

____

Responsible Party Signature/Date

V. Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following:

Check	Disease	Relationship	Check	Disease	Relationship
	Arthritis, Gout			Asthma, Hay Fever	
	Cancer			Chemical Dependency	
	Diabetes			Heart Disease, Strokes	
	High Blood Pressure			Kidney Disease	
	Tuberculosis			Other	

VI. Medical History

What is the reason for your visit today?

____

____

____

Check the symptoms you currently have or have had in the past year:

GENERAL
__ Chills
__ Depression/Nervousness
__ Dizziness/Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Loss of Weight
__ Numbness
__ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
__ Arms
__ Hips
__ Back
__ Legs
__ Feet
__ Neck
__ Hands
__ Shoulders

GENITO-URINARY
__ Blood in Urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination

GASTRONINTESTINAL
__ Appetite poor
__ Bloating
__ Bowel changes
__ Constipation
__ Diarrhea
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal bleeding
__ Stomach pain
__ Vomiting
__ Vomiting blood

CARDIOVASCULAR
__ Chest Pain
__ High/Low Blood Pressure
__ Irregular/Rapid heart beat
__ Poor circulation
__ Swelling of ankles
__ Varicose veins

EYE, EAR, NOSE, THROAT
__ Bleeding gums
__ Blurred vision
__ Crossed eyes
__ Difficulty swallowing
__ Double vision
__ Earache/Ear discharge
__ Hay fever
__ Hoarseness
__ Loss of Hearing
__ Nosebleeds
__ Persistent cough
__ Ringing in ears
__ Sinus problems
__ Vision - flashes/halos

SKIN
__ Bruise easily
__ Hives
__ Itching/Rash
__ Change in moles
__ Scar
__ Sore that won't heal

MEN ONLY
__ Erection difficulties
__ Lump in testicles
__ Penis discharge
__ Sore on penis
__ Other

WOMEN ONLY
__ Abnormal Pap Smear
__ Bleeding between periods
__ Breast Lump
__ Extreme menstrual pain
__ Hot flashes
__ Nipple discharge
__ Painful Intercourse
__ Vaginal discharge
__ Other
Date of last period ______
Date of last Pap ________
Have you had a mammogram? _______
Are you pregnant? ______
Number of children _____

Check (√) conditions you currently have and mark (X) conditions you have had in the past

__ AIDS
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding Disorders
__ Breast Lump
__ Cancer
__ Cataracts
__ Chemical Dependency
__ Chicken Pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Heart Disease
__ Hepatitis
__ Herpes
__ High Cholesterol
__ HIV Positive
__ Kidney Disease
__ Liver Disease
__ Measles
__ Migraine Headaches
__ Multiple Sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate Problem
__ Rheumatic Fever
__ Scarlet Fever
__ Stroke
__ Thyroid Problems
__ Tuberculosis
__ Ulcers
__ Venereal Disease

VII. Medication and Allergies

List medications you are currently taking:

____

____

Pharmacy Name ______________________________ Pharmacy Number ___________________________________

List allergies to medications or substances:

____

____

VIII. Health Habits

Health Habits: Check which substances you use and describe how much you use:
__ Caffeine _________________
__ Drugs ___________________
__ Tobacco _________________
__ Other ___________________

Occupational: Check if your work exposes you to the following:
__ Stress
__ Heavy Lifting
__ Hazardous Substances
__ Other ______________

IX. Signatures

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____ Date ________________________

Reviewed By ____ Date ________________________