



Date: \_\_\_\_\_

## History and Physical

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

| Chief Complaint (reason you are being seen today) |
|---|
|   |
|   |

| History of Present Illness |
|----------------------------|
|                            |
|                            |
|                            |
|                            |

| Medication(s) (Please list all medication you are currently taking) |                  |
|---|------------------|
| Name of Medication:   | Dose/Directions: |
|   |                  |
|   |                  |
|   |                  |
|   |                  |

| Medical History (Please check all that apply) |                          |                          |                              |                          |                       |
|---|--------------------------|--------------------------|------------------------------|--------------------------|-----------------------|
| <input type="checkbox"/>                      | Headache/Migraine        | <input type="checkbox"/> | Myocardial Infarction        | <input type="checkbox"/> | Genitourinary Disease |
| <input type="checkbox"/>                      | Headache/Tension         | <input type="checkbox"/> | Heart Murmur                 | <input type="checkbox"/> | Venereal Disease      |
| <input type="checkbox"/>                      | Epilepsy/Seizures        | <input type="checkbox"/> | Hypertension                 | <input type="checkbox"/> | Arthritis             |
| <input type="checkbox"/>                      | Cerebral Vascular        | <input type="checkbox"/> | COPD                         | <input type="checkbox"/> | Cancer                |
| <input type="checkbox"/>                      | Other Neuromuscular      | <input type="checkbox"/> | Asthma                       | <input type="checkbox"/> | Tuberculosis          |
| <input type="checkbox"/>                      | Head Injury              | <input type="checkbox"/> | Peptic Ulcer Disease         | <input type="checkbox"/> | HIV                   |
| <input type="checkbox"/>                      | Spinal Cord Injury       | <input type="checkbox"/> | Bleeding Disorder            | <input type="checkbox"/> | Alcohol Abuse         |
| <input type="checkbox"/>                      | Cervical Cord Injury     | <input type="checkbox"/> | Anemia                       | <input type="checkbox"/> | Smoking               |
| <input type="checkbox"/>                      | Peripheral Nerve         | <input type="checkbox"/> | Diabetes                     | <input type="checkbox"/> | Drug Abuse            |
| <input type="checkbox"/>                      | CNS Malignancy           | <input type="checkbox"/> | Peripheral Vascular Disease  | <input type="checkbox"/> | Exposures             |
| <input type="checkbox"/>                      | Depression               | <input type="checkbox"/> | Thyroid Disease              | <input type="checkbox"/> | Mumps                 |
| <input type="checkbox"/>                      | Anxiety                  | <input type="checkbox"/> | Menstrual/Sexual Dysfunction | <input type="checkbox"/> | Measles               |
| <input type="checkbox"/>                      | Coronary Artery Disease  | <input type="checkbox"/> | Other Endocrine              | <input type="checkbox"/> | Allergies             |
| <input type="checkbox"/>                      | Arrhythmias              | <input type="checkbox"/> | Liver Disease/Hepatitis      | <input type="checkbox"/> | Rheumatic Fever       |
| <input type="checkbox"/>                      | Congestive Heart Failure | <input type="checkbox"/> | Renal Disease                | <input type="checkbox"/> | Other                 |

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