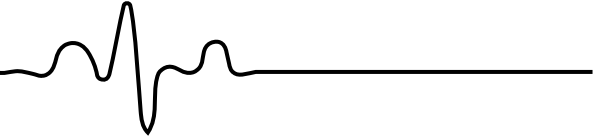




Dr. Mani Khoshnejad, M.D.



Current Medications

Patients Name: _____ Date of Birth: ___ / ___ / ___ Date: ___ / ___ / ___

Please list of any medications take on a regular basis. Include any prescribed or over the counter medications. (i.e. ointments, supplements, topical gels, pain relievers, etc.)

No Current Medications

| Medication Name Dose: | Frequency: |
|-------------------------|------------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |
| 11. | |
| 12. | |

By signing this form, I acknowledge that the information above will help my provider during the time of my visit to ensure an accurate treatment. I also agree I filled out the above form and that all information above is complete and true, to the best of my knowledge.

Patient Signature

___ / ___ / ___
Date

Legal Guardian Signature (If applicable)

___ / ___ / ___
Date

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