**B Kalantarian, MD, PLASTIC SURGERY**

Medical History

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any drug related allergies or intolerances:

2. Please list all major illnesses or hospitalizations along with approximate dates:

3. Please list all previous operations along with approximate dates and Surgeon’s name:

4. Please list all current medications (include over the counter medicines, aspirin, birth control pills, diet pills, vitamin E or herbal preparations) along with dosage:

HEIGHT: \_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_ Family history of breast cancer? YES/ NO

Last Mammogram? \_\_\_\_\_\_\_\_\_\_ Plan for future children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Cosmetic Questions:** | | | | **Female Questions:** | | | |
| Yes | | No | | Yes | | | No |
| Have you had Botox? |  |  | Date of last injection? | | Are you pregnant? |  |  |
| Have you had any fillers? |  |  | Date of last injection? | | Are you lactating? |  |  |
| Have you had any laser treatments? |  |  | Type: Date: | | Number of pregnancies? |  |  |
| Do you use self tanner? |  |  |  | | Number of children? |  |  |
| Do you wear sunscreen? |  |  |  | | Did you breast feed? |  |  |
| Do you have any tattoos? |  |  |  | | **Date of last mammogram?** |  |  |
| Have you had any chemical peels? |  |  | Type: Date: | | Do you take birth control pills or hormone replacement? |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Conditions**  (Please check any that apply to you): | | | | | | | | | | | |
| **Past** | | | **Present** | | | **Past** | | | **Present** | | |
| Yes No | |  | Yes | | No | Yes | No | | Yes | | No |
|  |  | Heart Trouble | |  |  |  |  | Bleeding Disorder | |  |  |
|  |  | Mitral valve prolapse | |  |  |  |  | Liver/Kidney disease | |  |  |
|  |  | Pacemaker | |  |  |  |  | Blood Transfusion | |  |  |
|  |  | High Blood pressure | |  |  |  |  | Bad reaction to anesthetics | |  |  |
|  |  | Anemia | |  |  |  |  | Hepatitis | |  |  |
|  |  | Asthma | |  |  |  |  | Psychiatric disorder | |  |  |
|  |  | Lung problems | |  |  |  |  | Cold sores | |  |  |
|  |  | Diabetes | |  |  |  |  | Taking Accutane | |  |  |
|  |  | HIV/AIDS | |  |  |  |  | Cancer | |  |  |
|  |  | Blood clots | |  |  |  |  | Headaches | |  |  |
|  |  | Difficulty breathing through nose | |  |  |  |  | History of overgrown or keloid scars | |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Social History** (Please check yes/no or fill in blank) | | | **Family History** (Please check any that apply to your immediate family members): | | |
| Yes | | No | Yes | | No |
| Have you ever smoked: |  |  | Bad Reaction to anesthesia |  |  |
| Do you currently use tobacco? |  |  | Alcoholism |  |  |
| How many packs per day? |  |  | Allergies |  |  |
| How long? |  |  | Bleeding tendencies |  |  |
| Do you drink alcohol? |  |  | **Cancer** |  |  |
| 0-1 drinks/day |  |  | Diabetes |  |  |
| 2-3 drinks/day |  |  | Heart Attacks |  |  |
| 4+ drinks/day |  |  | High Blood pressure |  |  |
| Alcohol/Drug dependency problems |  |  | Psychiatric Problems |  |  |

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