**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? |  |  |

|  |
| --- |
| **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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