S. Daniel Golshani, M.D., F.A.C.S.
Plastic & Reconstructive Surgery
Aesthetic Surgery

Patient Information

Name:__________________________________ **Age**:_______ **Sex**:________ **Date**:__________
Address:____
Email:_____________________________________ **Marital Status:**_____________________
Social Security #______-______-______ **Birthday**___________ **Driver's Lic#**_____________
Home #:___________________ **Cell#**:____________________ **Work#**__________________
Occupation:_____________________________ **How did you hear about us**:______________
Purpose of Consultation:____
Emergency Contact/Relation to you: ____

I. Medical Questionnaire: (Please Indicate with a "X" all that apply)

Have you ever had any heart Problems?

High Blood Pressure _____ Low blood Pressure _____
Heart Attack _____ Heart Murmur _____
Chest Pain/tightness _____ Irregular Heart Beat _____
Shortness of Breath _____

Have you ever had any Lungs Problems?

Bronchitis/ Pneumonia ____ Asthma ______
Shortness of Breath ____ Tuberculosis ______

Have you ever had any eye, ear, nose or throat problems?

Dry eyes _____ Blurred Vision ______
Glaucoma _____ Corrective Lenses ______
Ear Disease _____ Nose Bleed ______
Difficult Bleeding _____ Nasal Allergies ______
Sinus Disease _____ Other_____________________________

Have you had Gastrointestinal Problems?

Ulcer ______ Gastritis ______
Colitis ______ Diverticulitis ______

Have you ever had any Musculosketal/ Neurological Problems?

Convulsions ______ Epilepsy ______
Headaches ______ Arthritis ______
Other:

Have you ever been treated for psychiatric/ emotional Problems?

Depression ______ Anxiety ______
Other:

Have you ever had any Hematological / Metabolic Problem?

Anemia ______ Bleeding Problems ______
Blood Transfusion ______ AIDS Virus Exposure ______
Autoimmune Disease ______ Diabetes ______
Thyroid Disease ______ Hepatitis ______

Do you have any Medical Problems that have not been Covered?___________________________
Do you smoke Cigarettes? _______________ How Much? _________________________________
Do you Drink Alcoholic Beverages?______________ Socially_____________ Daily_____________
Patients Height________________________________ Patients weight________________________
Do you take any Diet Medication? Yes_________ No_______________

II. Medical History

Name & City of Your Personal Physician:____
Are you presently under the care of a physician for any medical condition?_______________
____

A. Surgical History- Please list all Surgeries (including Cosmetic)

Operations	Surgeon name	Year of Operations

B. Hospitalization (other than Surgery)

Illness	Physician/ Date

III. Medications & Vitamins/ Diet Pills

Name of Drug	Strength/ Dosage	Condition Treated

IV. **Allergies** (List any allergies to any Medication, foods, Tape or antiseptic cleaners or Latex allergies)
____
____

V. **Family History**(Please indicate if any immediate Family Member has ever had any of the Following)

Heart Disease ______ Bleeding Disorder ______
Diabetes: _______ Autoimmune Disease _______
Anesthetic Complications_______________ Other_________________________________

Date: _____________________ Patient Signature:_______________________________

Witness Signature:_____________________________