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#						
	How did you hear about us:					
Purpose of Consultation:						
Emergency Contact/Relation to you	:					
I. Medical Questionnaire:	(Please Indicate wit	h a "X" all th	at apply)			
Have you ever had any heart Prob	lems?					
High Blood Pressure	Low blood P	ressure				
Heart Attack	Heart Murm	ur				
Chest Pain/tightness	Irregular Hea	art Beat				
Shortness of Breath		_				
Have you ever had any Lungs Pro	blems?					
Bronchitis/ Pneumonia	Asthma					
Shortness of Breath	Tubercul	osis				
Have you ever had any eye, ear, n	ose or throat problem	s?				
Dry eyes	Blurred V					
Glaucoma		e Lenses				
Ear Disease	Nose Ble					
Difficult Bleeding	Nasal A					
Sinus Disease	Other	nergies				
Silius Discase	Ouici_					
Have you had Costraintestinal Pro	hlama?					
Have you had Gastrointestinal Pro Ulcer	Gastritis					
Colitis	Gastritis Diverticu	litia				
Conus	Diverticu	11118				
II M M M 1	4-1/NI1:1 D	1. 1 0				
Have you ever had any Musculosk	_	roblems?				
Convulsions	Epilepsy					
Headaches	Arthritis					
Other:						
Have you ever been treated for psy		Problems?				
Depression	Anxiety					
Other:						
Have you ever had any Hematolog	gical / Metabolic Prob	olem?				
Anemia	Bleeding P					
Blood Transfusion		rus Exposure				
Autoimmune Disease		1				
Thyroid Disease	Hepatitis					
Inytota Discase						

Do you smoke Cigarettes?	Do you	have any Medical Problems that have	not been Covered?			
Patients Height	Do you	smoke Cigarettes?	How Much?			
Patients Height	Do you	Drink Alcoholic Beverages?	Socially	Daily		
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 Heart Disease Bleeding Disorder Diabetes: Autoimmune Disease Anesthetic Complications Other Patient Signature: Patient Signature:	Patients	s Height	Patients weight			
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		Anesthetic Complications	Other			
		Date: Patie	ent Signature:			