Name: _____

RADY RAHBAN, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

DOB: _____

## ALLERGIES AND SENSITIVITIES

Check Yes or No if you have a history of skin reaction or other illness following contact with:

YES NO

- ☐ ☐ Penicillin, Sulfa or other antibiotic
- ☐ ☐ Morphine, Codeine, Demerol or narcotic
- ☐ ☐ Novocain, Lidocaine or local anesthetics
- ☐ ☐ Tetanus toxoid or serums
- ☐ ☐ Adhesive tape
- ☐ ☐ Iodine, Betadine, Chlorhexidine or Phisohex
- ☐ ☐ Tincture of Benzoin
- ☐ ☐ Latex rubber

List other drug, medicine or other substance here:

## DRUGS AND MEDICINES

Check Yes or No box if you have taken any of the following within the last 6 months:

YES NO

- ☐ ☐ Cortisone, prednisone or ACTH
- ☐ ☐ Diuretics or water pills
- ☐ ☐ Blood pressure medication
- ☐ ☐ Steroids or bodybuilding drugs
- ☐ ☐ Seizure medication
- ☐ ☐ Insulin or diabetes medication
- ☐ ☐ Headache or migraine medications
- ☐ ☐ Asthma medication
- ☐ ☐ Heart medication
- ☐ ☐ Anticoagulants or blood thinners
- ☐ ☐ Pain pills
- ☐ ☐ Appetite suppressants or diet pills
- ☐ ☐ "Fen-Phen," Redux, Pondimin, phentermine or fenfluramine
- ☐ ☐ Sedatives, tranquilizers or sleeping pills
- ☐ ☐ Antidepressants, antipsychotics or nerve pills
- ☐ ☐ Recreational or illegal drugs
- ☐ ☐ Homeopathic or herbal medicines (list below)

## MEDICATIONS THAT CAUSE BLEEDING

Do you regularly take any of the following:

YES NO

- ☐ ☐ Aspirin or aspirin-containing medications
- ☐ ☐ Ibuprofen (Motrin, Advil & Nuprin)
- ☐ ☐ Ketoprofen (Aleve)
- ☐ ☐ Vitamin E (excluding E in multivitamin)
- ☐ ☐ Anti-inflammatories or muscle relaxants

List **ALL drugs** or medications currently used:

## SURGERY

Check Yes or No box for each question:

YES NO

- ☐ ☐ Abnormal healing or scar formation
- ☐ ☐ Adverse or unusual reaction to surgery
- ☐ ☐ Abnormal bleeding
- ☐ ☐ Do you know of any reason you should not undergo surgery and anesthesia?

## IMPORTANT MEDICAL CONDITIONS

Check Yes or No box if you have been diagnosed or ever received treatment for any of the following:

YES NO

- ☐ ☐ Anaphylaxis or severe allergy attack
- ☐ ☐ Migraines, headaches or chronic head pain
- ☐ ☐ Chronic fatigue syndrome
- ☐ ☐ Seizures
- ☐ ☐ Strokes
- ☐ ☐ Glaucoma
- ☐ ☐ Cataracts or cataract surgery
- ☐ ☐ Lasik or laser vision correction
- ☐ ☐ Stiff neck
- ☐ ☐ Back problems
- ☐ ☐ Artificial joint replacement
- ☐ ☐ Bell's palsy or neurological problems
- ☐ ☐ Asthma, TB, emphysema or chest disease
- ☐ ☐ Pneumonia
- ☐ ☐ Pulmonary embolus
- ☐ ☐ High blood pressure
- ☐ ☐ Heart attack, angina, palpitations or irregular heartbeats
- ☐ ☐ Rheumatic fever or congenital heart disease
- ☐ ☐ Chest pain or angina
- ☐ ☐ Shortness of breath, dizziness or fainting
- ☐ ☐ Ankle swelling
- ☐ ☐ Angioedema, persistent or unusual swelling
- ☐ ☐ Pacemaker
- ☐ ☐ Artificial heart valve
- ☐ ☐ Mitral valve prolapse
- ☐ ☐ Poor circulation, leg ulcers or peripheral vascular disease
- ☐ ☐ Splenectomy (removal of spleen)
- ☐ ☐ Phlebitis, blood clots or varicose veins
- ☐ ☐ Ulcer disease
- ☐ ☐ Pancreatitis
- ☐ ☐ Inflammatory bowel disease or bowel problems
- ☐ ☐ Gastro esophageal reflux
- ☐ ☐ Hepatitis, jaundice, cirrhosis or liver disease
- ☐ ☐ Blood transfusion
- ☐ ☐ HIV or AIDS
- ☐ ☐ Anemia or blood disorder
- ☐ ☐ Frequent nosebleeds or heavy menstrual periods
- ☐ ☐ Easy bruising
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid problem or Graves' disease
- ☐ ☐ Kidney failure, kidney or prostate problems
- ☐ ☐ Lupus, arthritis or autoimmune disease
- ☐ ☐ X-Ray treatments or radiation therapy
- ☐ ☐ Severe snoring or sleep apnea
- ☐ ☐ Sleep disorder

## DENTURES

- ☐ ☐ Capped teeth, bridges or veneers
- ☐ ☐ Loose teeth or gum disease
- ☐ ☐ Other oral/dental problems

## ANESTHESIA

- ☐ ☐ Adverse or unusual reaction to anesthesia
- ☐ ☐ Do you have a blood relative who had anesthesia complications of any kind?

## ADDITIONAL MEDICAL CONDITIONS

Check Yes or No the box if you have been diagnosed or ever received treatment for any of the following:

YES NO

- ☐ ☐ Alcohol abuse or alcoholism
- ☐ ☐ Drug abuse or addiction
- ☐ ☐ Psychological or emotional problems
- ☐ ☐ Depression
- ☐ ☐ Personality disorder
- ☐ ☐ Bipolar or manic depressive illness
- ☐ ☐ Schizophrenia
- ☐ ☐ Nervous breakdown
- ☐ ☐ Claustrophobia or panic attacks
- ☐ ☐ Body Dismorphic Disorder (BDD)
- ☐ ☐ Eating disorder, anorexia or bulimia
- ☐ ☐ Currently in therapy or counseling
- ☐ ☐ Currently confused, depressed or having suicidal thoughts
- ☐ ☐ Is there violence in your home?
- ☐ ☐ Is anyone threatening you or making you feel bad about yourself?
- ☐ ☐ Is there someone close to you, or are there members of your family who strongly object to your having plastic surgery?

List **other medical conditions** here:

List all previous **surgical procedures** you have undergone & approximate date(s):

*I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.*

_____ _____ _____ _____

patient signature | date | witness signature | date

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