SERENITY PLASTIC SURGERY
ALI SAJJADIAN, M.D., F.A.C.S.

Name: _____ Date: _____

1. Please list any drug related allergies or intolerances:

_____

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

_____

3. Please list all previous operations along with approximate dates:

_____

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:

_____

5. Medical Conditions (Please check any ailments 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						Difficulty breathing through nose		
		High Blood pressure						Bad reaction to anesthetics		
		Anemia						Hepatitis		
		Asthma						Psychiatric disorder		
		Lung problems						History of overgrown or keloid scars		
		Diabetes						Taking Accutane		
		HIV/AIDS						Cancer		
		Blood clots						Headaches		
		Blood transfusion						Cold Sores		

6. Social History (Please circle answer or fill in blank)**:**

Have you ever smoked?	Yes	No	
Do you currently use tobacco?	Yes	No	
How many packs per day?	_____		
How long?	_____ yrs.		
Do you drink alcohol?	Yes	No	
0-1 drinks/day			
2-3 drinks/day			
4+ drinks/day			
Indicate if drugs or alcohol ever pos ed a dependency problem for you:	Drugs: Alcohol:		

7. Family History (Please check any ailments that apply to your immediate family members)**:**

Yes		**No**
Bad reaction to anesthesia		
Alcoholism		
Allergies		
Bleeding tendencies		
Cancer		
Diabetes		
Heart Attacks		
High Blood Pressure		
Psychiatric Problems		

8. Cosmetic Questions:

	Yes	No	
Have you had Botox injections?			Date of last injection: _____
Have you had any fillers?			Date of last injection: _____
Have you had any laser treatments?			Type: _____ Date: _____
Have you had any chemical peels?			Type: _____ Date: _____
Do you wear sunscreen?			
Do you have any tattoos?			
Do you use self tanner?			

9. Female Questions:

Are you pregnant?	Yes No
Are you lactating?	Yes No
Number of pregnancies: _____	
Number of children: _____	
Did you breast feed?	Yes No
Date of last mammogram: _____	
Do you take birth control pills or hormone replacement?	Yes No