RADY RAHBAN, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

Name:_____ D.O.B._____

HEALTH DISCLOSURE STATEMENT

ALLERGIES AND SENSITIVITIES Is there any history of skin reaction or other illness following contact with: (If yes, please circle item)

☐ yes ☐ no Penicillin, Sulfa or other antibiotic?
☐ yes ☐ no Morphine, Codeine, Demerol or narcotic?
☐ yes ☐ no Novocain, Lidocaine or local anesthetics?
☐ yes ☐ no Tetanus toxoid or serums?
☐ yes ☐ no Adhesive tape?
☐ yes ☐ no Iodine, Betadine, Chlorhexidine or Phisophex ?
☐ yes ☐ no Tincture of Benzoin?
☐ yes ☐ no Latex rubber?
☐ yes ☐ no Other drug medicine of other substance? (if yes list here)

_____
_____

DRUGS AND MEDICINES Have you, within the last *6 months*, taken any of the following:
(If yes, please circle item)

☐ yes ☐ no Cortisone, prednisone or ACTH?
☐ yes ☐ no Diuretics or water pills?
☐ yes ☐ no Blood pressure medication?
☐ yes ☐ no Steroids or body building drugs?
☐ yes ☐ no Seizure medication?
☐ yes ☐ no Insulin or diabetes medication?
☐ yes ☐ no Headache or migraine medications?
☐ yes ☐ no Asthma medication?
☐ yes ☐ no Phen-Phen or Redux?
☐ yes ☐ no Birth Control Pills?
☐ yes ☐ no Antibiotics?
☐ yes ☐ no Heart medication?
☐ yes ☐ no Anticoagulants or blood thinners?
☐ yes ☐ no Pain pills?
☐ yes ☐ no Appetite suppressants or diet pills?
☐ yes ☐ no Sedatives, tranquilizers or sleeping pills?
☐ yes ☐ no Antidepressants, antipsychotics or nerve pills?
☐ yes ☐ no Recreational or illegal drugs?
☐ yes ☐ no Homeopathic or herbal medicines? (List)
☐ yes ☐ no Other drugs or medications used? (If yes list here)

_____
_____

MEDICATIONS THAT CAUSE BLEEDING Do you take any of the following on a regular basis:
(If yes, please circle item)

☐ yes ☐ no Aspirin or aspirin containing medications?
☐ yes ☐ no Ibuprofen (Motrin, Advil & Nurpin)?
☐ yes ☐ no Ketoprofen (Aleeve)?
☐ yes ☐ no Vitamin E? (excluding that in a multivitamin)
☐ yes ☐ no Anti-inflammatories or muscle relaxants?

IMPORTANT MEDICAL CONDITIONS Have you ever had or received treatment for any of the following:

☐ yes ☐ no Hepatitis, liver disease?
☐ yes ☐ no HIV or AIDS?
☐ yes ☐ no Asthma? TB?
☐ yes ☐ no Pulmonary embolus?
☐ yes ☐ no High blood pressure?
☐ yes ☐ no Heart attack, palpitations?
☐ yes ☐ no Congenital heart disease?
☐ yes ☐ no Chest pain?
☐ yes ☐ no Dizziness?
☐ yes ☐ no Pacemaker?
☐ yes ☐ no Artificial heart valve?
☐ yes ☐ no Mitral valve prolapse?
☐ yes ☐ no Fainting?
☐ yes ☐ no Gastroesophageal reflux?
☐ yes ☐ no Chronic fatigue syndrome?
☐ yes ☐ no Psychological or emotional problems?
☐ yes ☐ no Shingles, cold sores, fever blisters or oral herpes?
☐ yes ☐ no Stomach ulcers?
☐ yes ☐ no Chronic or recent cough?
☐ yes ☐ no Phlebitis, blood clots or varicose veins?
☐ yes ☐ no Blood transfusions?
☐ yes ☐ no Adverse or unusual reaction to anesthesia?
☐ yes ☐ no Abnormal healing or poor scar formation?
☐ yes ☐ no Edema, persistent or unusual swelling?
☐ yes ☐ no Venereal disease?
☐ yes ☐ no Anxiety or "panic attacks?"
☐ yes ☐ no Migraines, headaches?
☐ yes ☐ no Anemia or blood disorder?
☐ yes ☐ no Abnormal bleeding?
☐ yes ☐ no Easy bruising?
☐ yes ☐ no Alcoholism?
☐ yes ☐ no Drug addiction?
☐ yes ☐ no Kidney failure?
☐ yes ☐ no Glaucoma?
☐ yes ☐ no Stiff neck?
☐ yes ☐ no Back problems?
☐ yes ☐ no Artificial joint?
☐ yes ☐ no Diabetes?
☐ yes ☐ no Thyroid problem or Graves disease?
☐ yes ☐ no Chronic head pain?
☐ yes ☐ no Seizures?
☐ yes ☐ no Stroke?
☐ yes ☐ no Bell's palsy or neurological problems?
☐ yes ☐ no Autoimmune disease? Lupus?
☐ yes ☐ no Depression?
☐ yes ☐ no Personality disorder?
☐ yes ☐ no Bipolar or manic depressive illness?
☐ yes ☐ no Currently in therapy or counseling?
☐ yes ☐ no Severe allergy attack?
☐ yes ☐ no X-Ray treatments or radiation therapy?
☐ yes ☐ no Sleep apnea?
☐ yes ☐ no Sleep disorder?
☐ yes ☐ no Body dimorphic disorder?

IMPORTANT MEDICAL CONDITIONS (Continued):

☐ yes ☐ no Eating disorder?
☐ yes ☐ no Other medical condition (If yes, list here)

_____
_____

ANESTHESIA
☐ yes ☐ no Do you have a blood relative who had anesthesia complications of any kind?

SMOKING
☐ yes ☐ no Do you currently smoke or have you smoked in the past? If yes:

Average number of packs smoked per day ____
Approximate number of total years smoking ____
If quit, number of years quit ____

DENTAL
☐ yes ☐ no Do you have dentures, veneers, capped teeth?

PREGNANCY (Women)
☐ yes ☐ no Are you sexually active?
☐ yes ☐ no Are you currently using birth control?
☐ yes ☐ no Are you pregnant?

Please list all *plastic surgery* procedures you have EVER UNDERGONE:

_____
_____
_____

Please list <u>all</u> *other* surgical procedures you have undergone:

_____
_____
_____

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.

Patient Signature/Date

Witness Signature/Date