NOUROLLAH GHORBANI, M.D.

INFORMATION FOR CASE HISTORY FILE

(PLEASE complete all items. PLEASE print.)

Date _____

Patient's Name _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Social Security # _____ E-mail Address _____

Patient's Occupation _____ Employer _____

Business Address _____ Business Phone _____ Ext. _____

Name of Spouse _____ Spouse's Occupation _____

Spouse's Employer _____ Address _____ Business Phone _____

Patient Referred by _____

Family Doctor or Internist _____ Address _____

Has this office ever seen or treated any member of your family? No _____ Yes _____

If yes, whom? _____
(Name) (Relationship)

Nearest Relative and Address _____
(Relatives not living at same address as patient)

Insurance Company _____ Subscribers Name _____

Group No. _____ Service Code _____ Contract No. _____

Medicare No. _____ Soc. Sec.No. _____

Person Financially Responsible Patient ❑ Spouse ❑ Other ❑

If " Other" , please complete the following:

Name _____ Relationship _____
(Party financially responsible)

Date of Birth _____ Social Security # _____ CDL _____

Address _____
(Street) (City) (State) (Zip)

Occupation _____ Employer _____

Business Address _____ Business Phone _____

PRESENT PROBLEM

Specific problem(s) for which you are seeking plastic surgery. _____

_____

PAST MEDICAL HISTORY

General Health: Good ☐ Fair ☐ Poor ☐

If not " Good", please explain _____

_____

_____

_____

Height _____ Weight _____

How long ago was your most recent physical check-up? _____

Did it include an electrocardiogram? No _____ Yes _____ Chest x Ray? No _____ Yes _____

Name and address of Doctor _____
(Name) (Address)

Serious Illnesses (Please List)

_____

_____

_____

Previous Surgery (Please List)

Operation	Year	Hospital	City	Surgeon's Name	Anesthesia (Local or General)

Have you had significant complications or aftereffects from any of these operations? No _____ Yes _____

If "Yes", please explain _____

_____

_____

INJURIES _____

Type	Year	Hospital	Doctor	After-Effects

FAMILY HISTORY

	Age	State of Health
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

Has any relative had:

Tuberculosis	No ___	Yes ___
Cancer	No ___	Yes ___
Diabetes	No ___	Yes ___
Epilepsy	No ___	Yes ___
Heart Disease	No ___	Yes ___
High Blood Pressure	No ___	Yes ___
Lung Disease	No ___	Yes ___
Kidney Disease	No ___	Yes ___
Blood Disease	No ___	Yes ___
Asthma	No ___	Yes ___
Mental Disease	No ___	Yes ___

MEDICATIONS, DRUGS

What is your approximate daily consumption of the following:

Tobacco _____

Alcohol _____

Coffee or Tea _____

Please list all medications you are now taking including aspirin, bufferin, birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, blood thinners, etc.

_____

_____

_____

_____

_____

Do you take any herbal medications? No_____ Yes_____

Have you had any illnesses of the following? (Circle if yes)

Brain	Nose	Chest	Stomach	Bladder	Arms
Eyes	Throat	Lungs	Intestines	Reproductive System	Legs
Ears	Neck	Heart	Kidney	Nervous System	

If circled, please explain: _____

_____

_____

_____

PERTINENT PREOPERATIVE INFORMATION

Are you allergic to any medicines? No ____ Yes ____

If yes which one(s)? _____

_____

Have you ever had a bad reaction to a general anesthetic (gas, Pentothal, etc.) ?	No ___	Yes ___
Has any member of your family ever had any bad reaction to a general anesthetic?	No ___	Yes ___
Have you required unusually large amounts of local anesthetic for medical or dental procedures?..	No ___	Yes ___
Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)	No ___	Yes ___
Are you allergic to adhesive tape?	No ___	Yes ___
Do you have high blood pressure?	No ___	Yes ___
Have you ever had Scarlet Fever or Rheumatic Fever?	No ___	Yes ___
Do you bleed unusually easily (from cuts, surgery, tooth extractions)?	No ___	Yes ___
Do you bruise unusually easily?	No ___	Yes ___
Are you a slow or poor healer?	No ___	Yes ___
Do you form large scars or keloids?	No ___	Yes ___
Do you have any skin disease, hives, eczema or rash?	No ___	Yes ___
Do you have frequent infections or boils?	No ___	Yes ___
Have you taken steroid medications, cortisone, or ACTH?	No ___	Yes ___
Do you have shortness of breath with walking?	No ___	Yes ___
Do you have, or have you had any significant emotional problems?	No ___	Yes ___
Have you ever had psychiatric care?	No ___	Yes ___
Have you ever been advised to see a psychiatrist?	No ___	Yes ___
Would you like any information on Advance Directives?	No ___	Yes ___

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, have insurance coverage with _____ and assign
Name of Insurance Carrier

directly to Nourollah Ghorbani, M.D. Inc., all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signature _____

Relationship to Patient _____
(Self Mother, etc.)