FARBOD ESMAILIAN | MD

BOARD CERTIFIED PLASTIC SURGEON

❒ Beverly Hills ❒ Los Alamitos ❒ Glendale Date_____

PLEASE PRINT

Patient Name: _____ Age: _____ Date of Birth _____/_____/_____
Last First Middle

Email: _____ Cell Phone: (_____) _____

Patient Address: _____ Home Phone: (_____) _____
Street

_____ Martial Status: S M W D
City state zip

Social Security #:_____ Driver License #:_____

Employer and Address: _____

Occupation: _____ Work Phone: (_____) _____

Spouse name or Emergency Contact: _____ Phone #: _____

Reason for your visit today? _____

How were you referred here? _____

BILLING INFORMATION

❒ Cash/Credit Card ❒ Financing ❒ Insurance

FOR OUR INSURANCE PATIENTS ONLY

❒ Work Related Injury? Date of Injury: _____

❒ HMO or MD Referral

Responsible Person: _____Relationship to Patient_____

Address: _____
street city state zip

Insurance Carrier _____ Group #: _____

Claim Office Address _____ Policy #: _____

Employer: _____Employer Phone: (_____) _____

Primary Holder Social Security: _____Driver License #: _____

2nd Insurance Carrier: _____Group #: _____

Claim Office Address: _____ Policy #: _____

Patient History

Name_____ Age _____ Height _____ Weight _____

Medical History

Have you ever experienced any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Asthma	❑	❑	Bladder or Kidney Infection	❑	❑
Chest Pain	❑	❑	Recent Cold or Flu	❑	❑	Kidney Failure	❑	❑
Heart Murmur	❑	❑	Bronchitis	❑	❑	Excessive Bleeding	❑	❑
Angina	❑	❑	Sinusitis	❑	❑	Other Kidney Problems	❑	❑
Congestive Heart Fail	❑	❑	Tuberculosis	❑	❑	Thyroid Dysfunction	❑	❑
Irregular Heart Failure	❑	❑	Emphysema	❑	❑	Hyperthyroidism	❑	❑
Other Heart Problems	❑	❑	Other Lung Problems	❑	❑	Hypothyroidism	❑	❑
			Hepatitis	❑	❑	Diabetes	❑	❑

If you answered "Yes" to any Thyroid question above, when was your last thyroid dysfunction blood test? _____

If you answered "Yes" to the Diabetes question above, what was your last HbA1c or blood sugar test? _____

Surgical History

Date	Operation/Complications	Anesthetic
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had an adverse reaction to an anesthetic? ❑ Yes ❑ No

If "Yes" please describe

_____

_____

Has any blood relative ever had an adverse reaction to an anesthetic? ❑ Yes ❑ No

If "Yes" please describe

_____

_____

Current Medications

_____

_____

_____

Allergies

Medicine	Description of Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Patient History (cont.)

Do you have Seizures? ❑ Yes ❑ No
If "Yes" how long have you had seizures? _____
When was your last seizure? _____
What is the cause of your seizures, if known? _____

Could you be pregnant at this time? ❑ Yes ❑ No
How many pregnancies have you had? _____
How many live births have you had? _____

Do you smoke? ❑ Yes ❑ No
How many per day? _____
How many years have you been smoking? _____

Do you use alcohol? ❑ Yes ❑ No
How much and how often? _____
Do you currently or ever have had alcohol dependency? _____
If "Yes" please describe _____

Do you use recreation drugs? ❑ Yes ❑ No
If "Yes" what kind? _____
Do you currently or ever have had a drug dependency? _____

Have you ever been tested for the HIV Virus? ❑ Yes ❑ No

Do you have a Family Physician? ❑ Yes ❑ No

If "Yes" please list name and telephone number below
Name _____Phone _____
Date of last visit _____

Please be assures that all information on this form is confidential and serves
Only to help formulate the anesthetic plan best suited to you.

Signature _____Date _____