Sina Kaderi M.D.

PLASTIC SURGEON

Patient Information

Medical History Form

Date: __/__/____

NAME & SURNAME:	PHONE NUMBER:
DATE OF BIRTH: ☐☐/☐☐/☐☐☐☐	E-MAIL:
GENDER: ◯ Female ◯ Male ◯ Other _____	PASAPORT NUMBER:

PLACE OF RESIDENCE (COUNTRY / CITY):

Which Surgical or Non-Surgical Procedure Are You Interested In?

◯ FACIAL SURGERY; PLEASE SPECIFY:

◯ NON-SURGICAL FACIAL PROCEDURES (FILLERS, BOTOX, ETC.); PLEASE SPECIFY:

◯ BODY SURGERY; PLEASE SPECIFY:

Medical History and Past Treatments

1-List All Surgeries or Procedures and Their Dates:

◯ AESTHETIC SURGERY:

◯ NON-AESTHETIC SURGERY:

◯ NON-SURGICAL AESTHETIC PROCEDURES: (E.G., FILLERS, BOTOX, ETC.)

2-Lifestyle and Habits

◯ SMOKING, Please specify the number of cigarettes/packs per day:	◯ ALCOHOL Please specify frequency and amount:
◯ ADDICTIVE SUBSTANCES:	

3–Please Inform Us About Your Medical Conditions:

- ◯ CURRENT PREGNANCY
- ◯ DIABETES
- ◯ HYPERTENSION
- ◯ ASTHMA
- ◯ HEART DISEASES
- ◯ LUNG DISEASES
- ◯ RHEUMATIC DISEASES
- ◯ THYROID DISEASES
- ◯ HEMATOLOGIC DISEASES
- ◯ COAGULATION DISORDERS
- ◯ HEPATITIS
- ◯ HIV / AIDS
- ◯ ALLERGIES – PLEASE SPECIFY:
- ◯ DRUG REACTIONS – PLEASE SPECIFY:
- ◯ OTHER MEDICAL CONDITIONS – PLEASE SPECIFY:

4–Medications You Regularly Use

PLEASE LIST THE NAMES OF THE MEDICATIONS AND THE MEDICAL CONDITIONS YOU USE THEM FOR:

- ◯ I confirm that the information I have provided is accurate.
- ◯ I have read, understood, and accepted the explicit consent statement.

SIGNATURE:

Doctor's Opinion