Sina Kaderi M.D. 💡

PLASTIC SURGEON /

Patient Information Medical H	listory Form	Date://
NAME & SURNAME:	PHONE NUMBER:	
DATE OF DI/DI/DIDD	E-MAIL:	
GENDER:	PASAPORT NUMBER:	

PLACE OF RESIDENCE (COUNTRY / CITY):

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

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

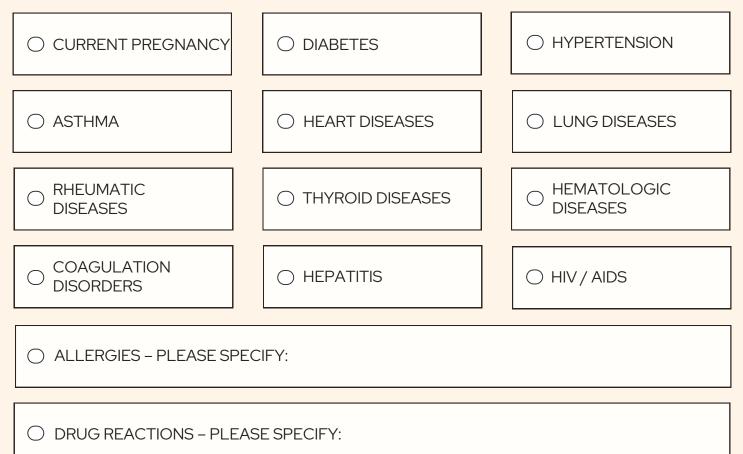
 SMOKING, Please specify the number of cigarettes/packs per day:

ADDICTIVE SUBSTANCES: ALCOHOL
Please specify
frequency and amount:

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3-Please Inform Us About Your Medical Conditions:



○ 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:

 \bigcirc I confirm that the information I have provided is accurate.

 \bigcirc I have read, understood, and accepted the explicit consent statement.

SIGNATURE:



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PLASTIC SURGEON

Doctor's Opinion

