KAYAN PLASTIC SURGERY — HISTORY INTAKE FORM

Patient Name ______________________________ **Birth Date** ____________________
Address ______________________________ **Phone #** ____________________
City ______________ **State** _______ **Zip** ___________ **Age** __________
Email ______________________________
Preferred Method of Contact ______________________________

Please answer all of the following questions as accurately as possible. Thank you.

Reason for your visit ______________________________
How did you hear about us? ______________________________

List any medical problems you have/had ______________________________
____
List previous surgeries ______________________________
____
Medications ______________________________
____
Allergies ______________________________

Smoking/vape ______________________________ **Alcohol (drinks per week)** ________
If former smoker, quit date ______________________ **Weight** ___________ **Height** ________
Exercise ______________________________ **Weight stable?** ____________________
Occupation ______________________________ **Number of children** ______________

Do you have any of the following?

Bleeding problems	yes ___	no ___	Currently pregnant/nursing	yes ___	no ___
History of a blood clot	yes ___	no ___	Wear glasses/contacts	yes ___	no ___
Problems with anesthesia	yes ___	no ___	Breathing problems	yes ___	no ___
Sleep apnea	yes ___	no ___	Diabetes	yes ___	no ___
Family history of breast cancer	yes ___	no ___			

Women Only

Bra size ____________ Last Mammogram date ________________ Results ____________________

I VERIFY THAT THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

X ______________________________ **DATE** ______________________
PATIENT SIGNATURE OR PARENT OF MINOR