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THE **DIAMOND**
FACE INSTITUTE

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HISTORY AND PHYSICAL

NAME _____ DATE OF BIRTH _____ AGE _____
Last First MI

SOCIAL

SEX M F MARRIED Y N OCCUPATION: _____

HABITS

SMOKE Y N Amt: _____ COFFEE/TEA/COLA Y N Amt: _____
ALCOHOL Y N Amt: _____ DAILY EXERCISE Y N Amt: _____

MEDICATIONS List dose or number of pills per day.

PRESCRIPTION DRUGS _____ NON-PRESCRIPTIONS (Vitamins, herbs, etc.) _____

REGULAR ASPRIN USE	<input type="checkbox"/> Y <input type="checkbox"/> N	DOSAGE & FREQUENCY	_____
NSAID (Advil, Motrin, Ibuprofen)	<input type="checkbox"/> Y <input type="checkbox"/> N	DOSAGE & FREQUENCY	_____
CORTIZONE INJECTIONS (Past year)	<input type="checkbox"/> Y <input type="checkbox"/> N	DATE(S) & INJECTION SITE	_____
DRUG ALLERGY	<input type="checkbox"/> Y <input type="checkbox"/> N	TYPE OF REACTION	_____
LATEX ALLERGY	<input type="checkbox"/> Y <input type="checkbox"/> N	TAPE ALLERGY	<input type="checkbox"/> Y <input type="checkbox"/> N

FAMILY HISTORY

Have any blood relatives ever had the following conditions?

ABNORMAL BLEEDING	<input type="checkbox"/> Y <input type="checkbox"/> N	ASTHMA	<input type="checkbox"/> Y <input type="checkbox"/> N	KIDNEY DISEASE	<input type="checkbox"/> Y <input type="checkbox"/> N
ABNORMAL CLOTTING	<input type="checkbox"/> Y <input type="checkbox"/> N	DIABETES	<input type="checkbox"/> Y <input type="checkbox"/> N	TUBERCULOSIS	<input type="checkbox"/> Y <input type="checkbox"/> N
ANESTHESIA PROBLEMS	<input type="checkbox"/> Y <input type="checkbox"/> N	HEART ATTACK	<input type="checkbox"/> Y <input type="checkbox"/> N	OTHER SERIOUS ILLNESS	<input type="checkbox"/> Y <input type="checkbox"/> N
CANCER	<input type="checkbox"/> Y <input type="checkbox"/> N	HYPERTENSION	<input type="checkbox"/> Y <input type="checkbox"/> N		

Please describe questions with a "yes" answer.

PERSONAL HISTORY Have you ever had the following conditions?

ABNORMAL BLEEDING	<input type="checkbox"/> Y <input type="checkbox"/> N	ASTHMA	<input type="checkbox"/> Y <input type="checkbox"/> N	HYPERTENSION	<input type="checkbox"/> Y <input type="checkbox"/> N
ABNORMAL CLOTTING	<input type="checkbox"/> Y <input type="checkbox"/> N	DIABETES	<input type="checkbox"/> Y <input type="checkbox"/> N	SLEEP APNEA	<input type="checkbox"/> Y <input type="checkbox"/> N
ACID REGURGITATION	<input type="checkbox"/> Y <input type="checkbox"/> N	HEART ATTACK	<input type="checkbox"/> Y <input type="checkbox"/> N	SNORING	<input type="checkbox"/> Y <input type="checkbox"/> N
ANEMIA	<input type="checkbox"/> Y <input type="checkbox"/> N	FAINTING SPELL	<input type="checkbox"/> Y <input type="checkbox"/> N	WEIGHT CHANGE (Past 12 mos.)	<input type="checkbox"/> Y <input type="checkbox"/> N
ANGINA	<input type="checkbox"/> Y <input type="checkbox"/> N	HEPATITIS	<input type="checkbox"/> Y <input type="checkbox"/> N	HISTORY OF HERPES	<input type="checkbox"/> Y <input type="checkbox"/> N

Please describe questions with a "yes" answer.

HAVE YOU EVER RECEIVED A TRANSFUSION? Y N YEAR _____
HAVE YOU BEEN TESTED FOR HIV? Y N YEAR _____ RESULTS: POSITIVE NEGATIVE
CONTACT LENSES Y N EYE GLASSES Y N HEARING AID Y N DENTURES Y N

SURGICAL HISTORY

YEAR TYPE OF PROCEDURE

HAVE YOU HAD: LOCAL ANESTHESIA Y N GENERAL ANESTHESIA Y N SPINAL/EPIDURAL Y N
LIST ANY COMPLICATIONS/REACTIONS YOU EXPERIENCED TO ANY/ALL ANESTHESIA.

PATIENT SIGNATURE _____ DATE ____/____/____