Behrooz Torkian, MD

Lasky Clinic - 201 South Lasky Drive, Beverly Hills, CA 90212
310.652.NOSE www.noseandface.com

1. Please specifically give the reason for your visit: _____

2. Please list all drug-related allergies or intolerances (or indicate none):_____

3. Are you under a doctor's care? _____ No _____ Yes NAME of physician: _____

PHONE: _____ ADDRESS: _____

Date of last complete physical examination _____

4. Do you have (or have you had) any of the following ailments?

PAST			PRESENTLY		PAST			PRESENTLY		PLEASE ANSWER
YES	NO		YES	NO	YES	NO		YES	NO	
☐	☐	Heart trouble	☐	☐	☐	☐	Nasal allergy	☐	☐	Do you currently smoke? Yes No
☐	☐	Mitral valve prolapse	☐	☐	☐	☐	Post-Nasal discharge	☐	☐	How many packs per day? _____
☐	☐	Diabetes	☐	☐	☐	☐	Headaches	☐	☐	Have you ever smoked? Yes No
☐	☐	Ulcers	☐	☐	☐	☐	Sinus infections	☐	☐	How long? _____ Years
☐	☐	Anemia	☐	☐	☐	☐	Nose bleeds	☐	☐	Do you drink alcohol? Yes No
☐	☐	Kidney Problems	☐	☐	☐	☐	Difficulty breathing	☐	☐	# drinks per day _____
☐	☐	Asthma/Lung trouble	☐	☐			through nose			History of drugs or alcohol dependency?
☐	☐	High blood pressure	☐	☐			**Pregnant**	☐	☐	____ Drugs ____ Alcohol
☐	☐	HIV/AIDS	☐	☐						
☐	☐	Hepatitis	☐	☐						

5. List all medications you are currently taking (including over the counter medicines, aspirin or aspirin containing medicines, birth control pills, diet pills, Vitamin E, or herbal preparations), along with the dosage and frequency:

_____

_____

_____

6. List all previous operations or major illnesses you have had, along with approximate dates: _____

_____

	YES	NO
7. Have you had a reaction to anesthetics?	☐	☐
Do you have a history of increased bleeding tendency?	☐	☐
Have you ever been under the care of a psychiatrist?	☐	☐
Do you wear glasses or contacts?	☐	☐
Do you have a history of bad scarring?	☐	☐

If yes, where? _____

8. **Family History**	YES	NO		YES	NO
Alcoholism	☐	☐	High Blood Pressure	☐	☐
Heart Attacks	☐	☐	Anesthetic Problems	☐	☐
Bleeding Tendencies	☐	☐	Allergies	☐	☐
Diabetes	☐	☐	Strokes	☐	☐
Myasthenia Gravis	☐	☐			

HEIGHT: _____ WEIGHT:_____

This information is correct and complete to the best of my knowledge, and I give my permission for you to contact and communicate with my physicians and insurance company.

(Signature) _____ **Date** _____