# ARY KRAU, M.D.

## BOARD CERTIFIED/ PLASTIC AND RECONSTRUCTIVE SURGERY

**NAME OF PATIENT**_____ **DATE**_____

**DATE OF BIRTH** _____ **AGE** _____ **SEX M / F** **MARRIED / SINGLE / SEP. / DIV. / WID.**

**ADDRESS** _____
**( PERMANENT)** **APT#** **CITY, STATE** **ZIP CODE**

_____
**( LOCAL)** **APT#** **CITY, STATE** **ZIP CODE**

**CELL PHONE**_____ **SOCIAL SECURITY NO.** _____

**REFERRED BY**_____ **YOUR E-MAIL ADDRESS**_____

**OCUPATION**_____ **EMPLOYED BY**_____

**EMPLOYER'S ADDRESS**_____ **BUSINESS PHONE** _____

**IF A PATIENT IS A MINOR, WHO IS LEGALLY RESPONSIBLE** _____

**YES OR NO NEXT TO EACH OF THE FOLLOWING QUESTIONS**

**1 - Have ever suffered from:**
**Heart disease□ High Blood Pressure□**
**Chest Disease□ Recent sore throat□ Cold or Flu□**
**Do you have a cough□ Have you suffered from Bronchitis□ Asthma□ Have you had a recent Chest x-ray or Electrocardiogram□**

**2 - Do you suffer from: Allergies or High Fever□**

**3 - Have you ever had: □ □**
**Diabetes Blood Diseases Kidney Disease□ □ □**
**Jaundice Glaucoma Cancer□**

**4 - Have you ever been treated for:**
**Anemia or Do You Bruise easily**

**5 - Have you had any serious illness or accidents**
_____
_____
_____

**6 - Are you Allergic to any medication, if so, which Drugs:** _____
_____
_____

**7 - Have you had any problems with Bleeding:** _____

**8 - Have you or any relative had a bad reaction from General or Local Anesthetic** _____

**9 - Have you taken any of the following drugs:**
**Aspirin□ Tranquilizers□ Water Pills□ Blood Pressure Pills□ Pain Pills□ Antihistamines□**
**If so, when:** _____

**10 - Do you have any of the following habits**
**Smoking: frequency** _____
**Alcoholic beverages: frequency** _____
**Recreational Drugs: frequency** _____

**11 - Have you had any previous surgery including plastic surgery: (What Kind/ When/ Where)**
_____
_____
_____
_____
_____
_____

**12 - Have you ever consulted a professional for Emotional problems:** _____□

**13 - What medications are you presently taking:**
_____
_____
_____

**14 - When was the last time you had a complete Medical examination**_____

**15 - Name of personal physician:** _____

**16. REASON FOR SEEING DR. KRAU:**

_____