Print this Form

Patient History Data

Name: _____ Age: _____ Today's Date: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Message Tel: _____

Marital Status: _____ Occupation: _____ Age of Children: _____

How were you referred to The Caniglia Center? _____

Please circle the surgical procedures you are interesed in: Chin Augmentation - Collagen - Eyelids - Face Neck Lift - Forehead Lift - Hair Transplant - Laser Resurfacing - Lip Advancement - Rhinoplasty

Others: _____

List all surgeries you have had (including plastic surgery): _____

_____

Were there any complications to any of the above mentioned procedures? _____

Dis you have a normal recovery? _____

Were you satisfied with the results? _____ If no, Why? _____

At what point did you consider surgical correction? _____

Have you discussed another doctor in regards to this type of surgical procedure? ◯ Yes ◯ No

If so, whom? _____

Have you discussed this surgery with your family? ◯ Yes ◯ No Are they agreeable? ◯ Yes ◯ No

Have you had cosmetic surgery in the past? ◯ Yes ◯ No If yes, What procedure? _____

Who performed the surgery? _____ By whom _____

When was your last physician examination? _____ By whom _____

Who is your family doctor? _____ Address _____

Would you object to our contacting him/her in regard to any medical problem that might arise? ◯ Yes ◯ No

MEDICAL HISTORY

Have you been affected by any of the following conditions?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Chest/Lung Problem
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding/Bruising
- ☐ Excessive Scarring
- ☐ Fever blisters/cold sores
- ☐ Heart Trouble
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Liver Problems
- ☐ Never Paralysis
- ☐ Poor Healing
- ☐ Problems w/Eyes
- ☐ Psychiatric Problems
- ☐ Stomach/Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Diseases

◯ Yes ◯ No Are you allergic to any medications? If so, What? _____

◯ Yes ◯ No Do you have an allergy to latex or rubber? Explain _____

◯ Yes ◯ No Are you now taking any medications including birth control pills? List all prescribed and over the counter medications including vitamins, list dosage and how often _____

◯ Yes ◯ No Have you ever received local anesthesia? (Novacaine or Xylocaine) by a dentist or doctor?

◯ Yes ◯ No Did you have any "reaction" to anesthesia? _____

◯ Yes ◯ No Has anyone in your family had "reactions" to anesthesia? Explain _____

◯ Yes ◯ No Are you pregnant at this time? When was your last menstrual period? _____

◯ Yes ◯ No Have you ever had any injuries or surgery to or around the face, neck, or eye area? When? _____

Explain _____

◯ Yes ◯ No Have you ever had a positive blood test for HTLV III or HIV (aids)?

◯ Yes ◯ No Do you smoke cigarettes, cigars, pipe or chew tobacco? (Circle) How much? _____

◯ Yes ◯ No Do you usually take more than 2 alcohol drink a day? How many? _____

◯ Yes ◯ No Have you ever received treatment for abuse of alcohol or drugs? _____

◯ Yes ◯ No Do you use recreational drugs? If so, What? _____

◯ Yes ◯ No Do you have any other medical problems that have not been covered? _____

Explain _____

Signed _____ Date _____

The information you have provided us is essential in our comprehensive evaluation of your case. Please write down any questions you have so we may discuss then in detail during our consultation period