# PATIENT HEALTH HISTORY

Name Age Today’s Date

Address Apt. #

City State Zip Code Email

Cell Phone Hm Tel. Wk Tel.

Marital Status: **S M D W** Occupation Age of Children

How were you referred to The Caniglia Center? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Please circle the surgical procedures you are interested in: Chin Augmentation – Eyelids – Face Neck Lift – Forehead Lift – Laser Resurfacing – Lip Advancement – Rhinoplasty (Nose)

**Other:**

At what point did you consider surgical correction?

Have you consulted 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? Where was it performed?

Were you satisfied with the results? Yes No If no, why?

Has anyone in your family or a close friend had cosmetic or reconstructive surgery?

What procedure was performed? By whom

When was your last physical 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 \_\_\_ Excessive Bleeding/Bruising \_\_\_ Poor Healing

\_\_\_ Arthritis \_\_\_ Excessive scarring \_\_\_ Problems w/Eyes

\_\_\_ Asthma \_\_\_ Fever Blisters/cold sores \_\_\_ Psychiatric problems

\_\_\_ Blood Transfusion \_\_\_ Heart Trouble \_\_\_ Stomach/Ulcers

\_\_\_ Chest/Lung Problems \_\_\_ Hepatitis \_\_\_ Thyroid problems

\_\_\_ Diabetes \_\_\_ High Blood Pressure\_\_\_ \_\_\_ Tuberculosis

\_\_\_ Dizziness \_\_\_ Liver Problems \_\_\_ Venereal diseases (syphilis,

\_\_\_ Epilepsy/Seizures \_\_\_ Nerve Paralysis gonorrhea)

Yes No Do you have an allergy to latex or rubber? Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Have you ever received local anesthesia (Novacaine or Xylocaine)?

Yes No Did you have any “reaction” to the 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 usually drink more than 2 alcohol beverages 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

|  |  |
| --- | --- |
| **Any and All Allergies:** | **Reaction:** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Over for page 2

|  |  |
| --- | --- |
| **Previous surgeries:** | **Year of surgery/Any complications with surgery or recovery?** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** (including vitamins & supplements) | **Dose** | **Frequency** | **Notes** |
|
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **I acknowledge that I am responsible for providing complete and truthful information regarding my medical history, including but not limited to all prior surgeries, chronic conditions, medications, allergies, and any other relevant health information. I understand that withholding or providing false information may affect my care and could result in adverse outcomes.**I acknoeldhe |

**Please answer the following questions:**

1. Can you walk up a flight of stairs without becoming short of breath? Y N
2. Do you smoke? Y N
3. Any cardiac history? Y N
4. Any recent or on-going chest pain or tightness? Y N
5. Any history of cancer? Y N

If yes, please explain:

Signed Date