PATIENT HISTORY DATA

Name _____ Age _____ Today's Date _____
Address _____ Apt. # _____
City _____ State _____ Zip Code _____ Cell Phone _____
Hm. Tel. _____ Wk Tel. _____ Message 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 – Collagen – Eyelids – Face Neck Lift – Forehead Lift – Hair Transplant – Laser Resurfacing – Lip Advancement – Rhinoplasty (Nose) Other:

_____

List all the surgeries you have had (including plastic surgery):_____
_____
Were there any complications to any of the above mentioned procedures? _____
Did you have a normal recovery? _____
Were you satisfied with the results? _____ If no, Why? _____
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 _____
___ Arthritis _____
___ Asthma _____
___ Blood Transfusion _____
___ Chest/Lung Problems _____
___ Diabetes _____
___ Dizziness _____
___ Epilepsy/Seizures _____
___ Excessive Bleeding/Bruising
___ Excessive scarring _____
___ Fever Blisters/cold sores
___ Heart Trouble _____
___ Hepatitis _____
___ High Blood Pressure _____
___ Liver Problems _____
___ Nerve Paralysis _____
___ Poor Healing _____
___ Problems w/Eyes _____
___ Psychiatric problems _____
___ Stomach/Ulcers _____
___ Thyroid problems _____
___ Tuberculosis _____
___ Venereal diseases (syphilis, gonorrhea) _____

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 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 smoke cigarettes, cigars, pipe or chew tobacco? (Circle) How much? _____
Yes No Do you usually take more than 2 alcohol drinks 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 them in detail during our consultation period.