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_____
___ 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 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:

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

Medication (including vitamins & supplements)	**Dose**	**Frequency**	**Notes**

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 _____

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.