Patient Information

Name:_____ Today's Date:_____

Address: Home_____
Street *City* *State* *Zip*

Business_____
Street *City* *State* *Zip*

Date of Birth: _____ Age: _____ Sex: (M) (F)

How were you referred to us?

_____

Name(s) of family members who have been treated by our staff

_____

What website(s) do you find helpful (mark all that apply)?

- ❑ Facialcosmeticsurg
- ❑ RealSelf
- ❑ Yelp
- ❑ Facebook
- ❑ Instagram
- ❑ Other: _____

Occupation: _____

Employer: _____

_____
Best Contact Number

_____
Alternative Number

_____
Email address

Medical History

Circle any of the following you have experienced:

Asthma	Arthritis	Venereal Disease	Other Blood Problems
Hay Fever	Arthritis therapy	AIDS / HIV	Substance abuse therapy
Nasal allergies	Steroid therapy	Frequent headache	Bouts of depression
Visual problems	Poor circulation	Excess Scarring	Nervous breakdown
Kidney trouble	Dizziness	Thyroid therapy	Psychiatric therapy
Bladder trouble	Convulsions	Frequent chest pain	Gall bladder trouble
Lung trouble	Skin infection	Paralysis	Stomach ulcers
Heart trouble	Skin irritation	Hormone therapy	Other stomach trouble
High blood pressure	Rashes	Anemia	Liver trouble
Diabetes	Fever Blisters	Profuse bleeding	Hepatitis A B C
Yellow Jaundice	Genital herpes	Excess bruising	

No Yes Have you ever had any surgery(s) or serious injury(s)? [Including cosmetic surgery]
Please list procedure, date and physician: _____

_____

No Yes Are you now taking any medications, herbal or weight loss supplements? Please list them:

_____

_____

No Yes Are you allergic or have sensitivities to any medication, creams, tape, make-up, etc.? Please describe reaction

_____

No Yes Have you ever taken the drug "Acutane"? When?_____

No Yes Do you smoke more than 10 cigarettes a day?

No Yes Do you drink more than 6 cups of coffee a day?

No Yes Do you usually drink two or more alcoholic beverages a day?

No Yes Have you or a relative ever had a blood clot or lung embolus? When?_____

Patient Information

When was your last physical examination?_____

Who is your primary care physician? _____ Phone Number: _____

No Yes May we contact him/her for additional information pertaining to your health?

Women Only Date of last menstrual period? _____

No Yes Do you have any other medical problems that have not yet been covered? Please explain:

_____

Services

Please indicate which procedure(s) are you interested in:

Surgical Services:

- ❑ Rhinoplasty (nose)
- ❑ Facelift
- ❑ Mini-Facelift/ Cheek
- ❑ Neck Lift
- ❑ Eyelid Surgery
- ❑ Brow Lift
- ❑ Chin Augmentation
- ❑ Scar Revision
- ❑ Protruding Ears
- ❑ Removal of cysts, warts, moles etc.
- ❑ Liposuction - Please list area(s): _____

Non-invasive services:

- ❑ Botox/ Dysport
- ❑ CoolSculpting
- ❑ CoolMini
- ❑Kybella
- ❑ Injectable fillers (Vollure, Voluma, Volbella, Juvederm Restylane, etc.)
- ❑Sculptra
- ❑ Silhouette Instalift
- ❑ Photo facials
- ❑ Chemical Peel
- ❑ Other_____

Please write, in your own words, what condition(s) you wish to discuss _____

_____

No Yes Do you desire improvement in both appearance and function?

No Yes Do you accept the fact that every medical and surgical treatment is associated with risk and other imponderables?

No Yes Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic, and other diagnostic services that the Center deems beneficial while you are under their care?

❑ I understand that the Kaniff Cosmetic Medical Center communicates electronically (email, text messaging, etc.,) and consent to receive such communications from the practice for appointment reminders, general information and marketing.

❑ I am aware that the practice HIPAA Privacy Policies are available on the website and in hard copy at the office for my review.

❑ I understand that Dr. Kaniff is licensed and regulated by the Medical Board of California.

Thank you. The above information you have provided is essential in our comprehensive evaluation in your case.

Patient Signature: _____ Date:_____