

## 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?  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

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

Best Contact Number \_\_\_\_\_

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

Alternative Number \_\_\_\_\_

- Facialcosmeticsurg     RealSelf  
 Yelp                       Facebook  
 Instagram  
 Other: \_\_\_\_\_

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:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Rhinoplasty (nose)                       | <input type="checkbox"/> Facelift                            | <input type="checkbox"/> Mini-Facelift/ Cheek | <input type="checkbox"/> Neck Lift     |
| <input type="checkbox"/> Eyelid Surgery                           | <input type="checkbox"/> Brow Lift                           | <input type="checkbox"/> Chin Augmentation    | <input type="checkbox"/> Scar Revision |
| <input type="checkbox"/> Protruding Ears                          | <input type="checkbox"/> Removal of cysts, warts, moles etc. |   |  |
| <input type="checkbox"/> Liposuction - Please list area(s): _____ |  |   |  |

#### Non-invasive services:

- |   |  |  |                                  |
|---|--|--|----------------------------------|
| <input type="checkbox"/> Botox/ Dysport   | <input type="checkbox"/> CoolSculpting | <input type="checkbox"/> CoolMini      | <input type="checkbox"/> Kybella |
| <input type="checkbox"/> Injectable fillers (Vollure, Voluma, Volbella, Juvederm Restylane, etc.) |  | <input type="checkbox"/> Sculptra      |                                  |
| <input type="checkbox"/> Silhouette Instalift   | <input type="checkbox"/> Photo facials | <input type="checkbox"/> Chemical Peel |                                  |
| <input type="checkbox"/> 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: \_\_\_\_\_