Name: Today’s Date: \_\_\_\_\_

Address: Home \_\_\_\_\_

*Street City State Zip*

Business \_\_\_\_\_

*Street City State Zip*

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: (M) (F)

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 Have you ever had any non-invasive cosmetic treatment?

Please list date(s) and provider(s): \_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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.

❑ Laser Re-Surfacing

**Non-invasive Services:**

❑ Botox/ Dysport/ Xeomin ❑ RF Microneedling ❑ Kybella

❑ Injectable Fillers ❑ Sculptra ❑ Hydrafacial

❑ Laser Re-Surfacing ❑ Photo Facial ❑ Chemical Peel

❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please write, in your own words, what area(s)/ condition(s) you wish to discuss \_\_\_\_\_

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 Facial Cosmetic Surgery Associates 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 of your care.*

Patient Signature: Date: \_\_\_\_