



**Dr. James Lacey**  
**Kanata Plastic & Cosmetic Surgery**  
 895 March Road, Kanata ON K2K1X7

**CNI Clinic**  
 Cosmetic Nurse Injectors



DATE: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ POSTALCODE: \_\_\_\_\_

OHIP: \_\_\_\_\_ DATE of BIRTH: \_\_\_\_\_

AGE \_\_\_\_\_ HEIGHT: \_\_\_\_\_ \*WEIGHT: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ CELL # \_\_\_\_\_

REASON FOR CONSULTATION: \_\_\_\_\_

INJECTION APPOINTMENT SCHEDULED?.....Y.....N WHEN? \_\_\_\_\_

**MEDICATIONS:**

List your medications:

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

**Do you take any of the following daily?**

Aspirin..... Y.....N  
 Vitamin E.....Y.....N  
 Fish oil..... Y.....N  
 Blood thinners....Y.....N

**Natural Supplements?**

Please List:

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

**Allergies:** Are you allergic to ANY medications?.....Y.....N

(List) \_\_\_\_\_

Are you allergic to **Latex**?.....Y.....N

Do you **smoke**?.....Y.....N How Much? \_\_\_\_\_

**MEDICAL CONDITIONS:**

Are you diagnosed with any of the following? Any Yes or No

heart problems eg: heart attack, angina etc..... \_\_\_\_\_  
 high blood pressure ..... \_\_\_\_\_  
 diabetes..... \_\_\_\_\_  
 asthma..... \_\_\_\_\_  
 bleeding disorders; blood clots ..... \_\_\_\_\_

Other **significant medical conditions** (please list) \_\_\_\_\_

**\*\*Please complete ALL sections\*\***