Smartlipo™ Consultation

Name: _____ Date: _____

Address: _____

City: _____State: _____ Zip: _____

Cell/Preferred Contact Number: _____

Email: _____

Male _____ Female _____ Date of Birth: _____ **Age?** _____

Have you ever had liposuction or reconstructive surgery before? ❑ YES ❑ NO List all areas and year:

_____

_____

What is your budget? _____ Do you need information on financing? Yes_____ or No _____

Patient History

It is imperative you provide all of your medical history during your consultation. Your consult form will be screened to determine if you are eligible for this procedure.

Date of Last Complete Physical: _____Date of EKG/ECG: _____

A current physical is required for surgery. Physical must be within 12 months of your selective surgery date. Contact your physician to fax a copy of your exam. EKG/ECG required if 50 years or previous cardiology issues (includes hypertension/high blood pressure).

Height _____ Weight _____

Are you Pregnant? Yes _____ No _____

Date of Last Menstrual Cycle (females only): _____ If not applicable, state why: hysterectomy, menopause, tubal ligation: _____

What is your Physician name/address/phone number: _____

_____

_____

If a medical condition exists, your physician may be contacted for clearance.

Have you ever been exposed to, or do you have any contagious diseases (for example HIV, Hepatitis, AIDS, STD, etc)? ❑ YES ❑ NO Which? _____

Do you keloid? ❑ YES ❑ NO (heavy scarring, overgrowth of tissue; typically seen in African Americans).

Do you have any bleeding problems (ie **anemia**)? Please list: _____
If yes, are you taking an iron supplement? ❑ YES _____include dosage ❑ NO

Any Blood Transfusions: ❑ YES ❑ NO If yes, why: _____

Do you have any kidney, heart, thyroid, diabetes, circulation, metabolic, blood pressure or any other diseases or problems? ❑ YES ❑ NO Which ones? _____

Do you have any known allergies? ❑ YES ❑ NO If yes, please list example, latex, tape, penicillin, aspirin, sulfa, codeine, etc. _____

Do you have or have you had in the past any problems taking medications? Allergy or adverse reactions? ❑ YES ❑ NO If yes, which ones? Include anesthesia and medications
_____

Do you take Aspirin, Coumadin, Excedrin, Motrin or anything which thins the blood, including Vitamin E and herbal supplements: garlic, ginger, ginseng, ginko)? ❑ YES ❑ NO

List **ALL Current Medications & Vitamins/Supplements in the last 6 months**

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

If necessary, write additional medications on this line: _____

Current Medical Problems:

1. _____
2. _____
3. _____
4. _____

List Past Surgeries: _____

_____

Overnight stays in hospital – include month and year of hospitalization (to **include child birth**)
_____

_____

If you have ever been pregnant, how many deliveries? _____ Any C-sections? ❑ YES ❑ NO

Any recent miscarriages or abortions, if so when: _____
We ask this question because a false positive pregnancy test will postpone your surgery. We cannot operate on a positive pregnancy regardless of the type of termination until we receive a negative test result.

Please check the areas you are considering:

- ❑ Arms (upper)
- ❑ Arm pit (Hyperhidrosis – sweat glands)
- ❑ Bra, Above (Above the bra)
- ❑ Bra, Under (Under the bra)
- ❑ Abdomen, Upper
- ❑ Abdomen, Lower
- ❑ Love Handles
- ❑ Back/Flanks
- ❑ Upper Shelf of Buttocks
- ❑ Buttocks Reduction
- ❑ Knees
- ❑ Saddle Bags
- ❑ Thighs, Partial Inner (Upper 4 inches)
- ❑ Thighs, Full Inner
- ❑ Thighs, Front
- ❑ Thighs, Back
- ❑ Male Breast Reduction
- ❑ Neck/Chin
- ❑ Brazilian Butt Lift {**BBL**} / Fat Transfer (hip or buttock)

What are your main concerns about SmartLipo?_____

_____

Your signature verifies you are providing accurate medical profile/history. Inaccuracies may result in our refusal to provide cosmetic services. Your information will be held in accordance with HIPPA – patient privacy act.

_____ _____

Signature Date