GUEST INFORMATION AND MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionnaire. All information is confidential.

FIRST NAME: _____ LAST NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE #: ( ) _____ EMAIL: _____

Are you currently under a physician's care?..... ☐YES ☐NO

Since when? _____ Why? _____

Are you taking any medication or substances? If ***Yes***, please list..... ☐YES ☐NO

_____

Do you routinely take health-related substances (i.e., vitamins or alternative medicine)? If ***Yes***, please list. ☐YES ☐NO

_____

Are you allergic to any medication or substances? If ***Yes***, please list..... ☐YES ☐NO

_____

Are you allergic to any metals or latex?..... ☐YES ☐NO

Do you have any other allergies? If ***Yes***, please list. ..... ☐YES ☐NO

_____

Have you taken aspirin or any other anti-inflammatory drugs in the past fourteen (14) days?..... ☐YES ☐NO

_____

Are you pregnant or suspect you may be? ..... ☐YES ☐NO

Have you ever been treated for or been told you might have heart disease? ..... ☐YES ☐NO

Do you have a pacemaker or an artificial heart valve implant?..... ☐YES ☐NO

Have you ever had rheumatic fever? ..... ☐YES ☐NO

Have you ever had a serious illness or previous surgery? (If ***Yes***, please list) ..... ☐YES ☐NO

Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?..... ☐YES ☐NO

_____

Do you have any blood disorders such as anemia, leukemia, etc? ..... ☐YES ☐NO

Have you ever bled excessively after being cut or injured? ..... ☐YES ☐NO

Have you had psychiatric treatment? ..... ☐YES ☐NO

Do you have any of the following:

Heart Murmurs	☐YES ☐NO	High or low blood pressure	☐YES ☐NO
Diabetes	☐YES ☐NO	Asthma	☐YES ☐NO
Epilepsy or seizure disorders	☐YES ☐NO		☐YES ☐NO

Do you have any disease, condition or problem not listed? If ***Yes***, please list..... ☐YES ☐NO

_____

Have you ever had BOTOX® Cosmetic or Dysport™ treatments? If ***Yes***, where?..... ☐YES ☐NO

_____

Have you ever had Restylane® or Perlane® treatments? If ***Yes***, where?..... ☐YES ☐NO

LIABILITY RELEASE ACKNOWLEDGEMENT AND WAIVER:

The undersigned, understands, acknowledges and agrees that: (i) I am aware that the facilities and services offered by Doctor's Weight Loss Centers, Inc. (referred to as "DWLC") involve risks; (ii) the information I have provided above is accurate and complete regarding my current health status; (iii) I am seeking the cosmetic treatment of my own free will; and (iv) I assume all risks associated therewith. On behalf of myself, my heirs and my assigns, I hereby release and discharge Doctor's Weight Loss Centers, Inc. and their respective staff and all employees and representatives from any and all claims or causes of actions arising out of or relating to my cosmetic treatment, including but not limited to those resulting from bodily injury, or theft, loss of, or damage to, property of mine unless due to the grow negligence or willful misconduct of DWLC or their respective employees.

NAME (PRINT): _____ (SIGNATURE): _____ DATE: _____