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 **<u>ALL</u>** **<u>Current Medications</u> & 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