



## Smartlipo™ & Laser Consult

**Please print**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Cell/Preferred Contact Number: \_\_\_\_\_

Email: \_\_\_\_\_

How did you hear about our services (website, Facebook, Instagram? **Were you referred to our center?**

If yes, **by whom:** \_\_\_\_\_

Desired Treatment Area(s)? \_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Age? \_\_\_\_\_

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ (provided by staff) **BMI** \_\_\_\_\_ (provided by staff)

Are you Pregnant? Yes \_\_\_\_ No \_\_\_\_

Have you had any previous liposuction surgery? Yes \_\_\_\_ No \_\_\_\_

Do you wish to treat Cellulite? \_\_\_\_ Stretchmarks \_\_\_\_ or Scars \_\_\_\_

Comments: \_\_\_\_\_

What is your budget?

- \$2,000 - \$5,000 (one to two areas)
- \$5,000 to \$7,000 (two to three areas)
- \$7,000 to \$10,000 (three to four areas)
- Do you plan to finance your surgery? We accept Care Credit, (6 to 48 months financing; you select the terms for repayment), United Medical Credit and Lending USA. Credit score check is conducted by the lending companies. Go their website for details.
- We accept all major credit cards: VISA, MasterCard, American Express, Discover, Diner's Club

Patient History – please print

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\*Date of Patient Examination: \_\_\_\_\_ \*Date of Proposed SmartLipo: \_\_\_\_\_

**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 for your chart. **EKG/ECG required if 50 years** or previous cardiology issues (includes hypertension).

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

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 \_\_\_\_\_Elasticity
- Abdomen, Upper (half-moon)
- Abdomen, Lower \_\_\_\_\_Elasticity
- Love Handles
- Back/Flanks
- Upper Shelf of Buttocks (“butt enhancement”)
- Buttocks Reduction
- Knees
- Saddle Bags
- Thighs, Partial Inner (Upper 4 inches)
- Thighs, Full Inner
- Thighs, Front
- Thighs, Back
- Male Breast Reduction
- Neck
- Cellulite:  Stage 1: \_\_\_\_\_  Stage 2: \_\_\_\_\_  Stage 3: \_\_\_\_\_

How much improvement in contouring and body change are you expecting?

- 99% - 80%       80%-60%       60%-40%       40%-20%

It is imperative you provide all of your medical history during your consult.  
Your consult form will be screened to determine if you are eligible for this procedure.  
Be honest to receive the best and safest treatment possible.

What is your Physician name/address/phone number: \_\_\_\_\_

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

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

Do you keloid?  YES  NO (heavy scarring, overgrowth of tissue; typically seen in African Americans).  
Our Esthetician can treat surgical scars 30-days post surgery.

Do you bruise easily?  YES  NO

Do you have any bleeding problems (ie anemia)? Please list: \_\_\_\_\_

If yes, are you taking an Iron supplement?  YES \_\_\_\_\_include dosage  NO

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 Medications (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. \_\_\_\_\_

Any Blood Transfusions:  YES  NO If yes, why: \_\_\_\_\_

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

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\*\*.

Have you been treated for any depression, emotional or psychiatric problems?  YES  NO

If yes, are you currently under care? With or without medication? \_\_\_\_\_  
\_\_\_\_\_

Have you ever been in recovery or been addicted to any substance?  YES  NO Which ones?  
\_\_\_\_\_

What are your main concerns about SmartLipo? \_\_\_\_\_  
\_\_\_\_\_

Do you understand the procedure, risks, expected outcomes, Pre & Post SmartLipo instructions and the importance of follow up care?  YES  NO

What are you still unclear about? \_\_\_\_\_

Have we now clarified and answered all your questions?  YES  NO

Your signature verifies that you are clear about this procedure.

Any failure to provide an accurate medical profile/history may result in our refusal of providing you services. Your information will be held in accordance with HIPPA – patient privacy act.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date