Norcal Liposculpture
Dr. Jack Friedlander

Vaser Liposuction Consultation

Patient Name___________________________ DOB_________________ Today's Date___________

Address___________________________ City_________________ State____________ Zip_______

Home (_____) ________________ Cell (_____) ________________ Work (____) _______________

Primary contact number? (H) (C) (W) Sex: M__ F __ Marital Status: S__ M__ W__ D__

Occupation ____________________________ Employer __________________________________

Emergency Contact ___________________ Relation ________________ Phone (____) _________

E-Mail Address ____

Would you like to receive future promotional events, discounts, and specials from Norcal Liposculpture? (Y) (N) Please note: Your e-mail address is used strictly for communication with you and will not be given out.

How did you hear about us? Website ___ Instagram ___ FB ___ Twitter ___ Google ____

Friend ___ (name)__________________________ Other (please specify) _____________________

HEALTH INFORMATION

Age:____ Current Weight: ____lbs. Height: ______ Office Use BMI: ___________

Is your general health good? (Y)___ (N) ____ Date of last physical: ____________________

Name of family physician: ____

What attracted you most to learning about Vaser Lipo? ___________________________________
____

What problem area(s) are you considering having treated? (Please circle area or areas)

Abdomen	Inner Thighs	Arms	Neck
Flanks (Muffin Top)	Outer Thighs	Upper Back (Bra Area)	Male Chest

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Are you pregnant or trying to become pregnant? (Y)___(N)___Do you use oral contraceptives? (Y)___ (N)____

Do you have any food or drug allergies? (Y) ___ (N) ____ If yes, please list: ____________________
____

Do you any neuromuscular or autoimmune diseases? (Y)___ (N) ____ List: _____________________
____

Do you have allergies to latex? (Y) ___ (N) ___ Do you have fear of needles? (Y)___ (N) ____

Do you smoke? (Y) ____ (N) ____ If yes, how much ____________ How often _______________

Do you take Asprin, Advil, Motrin, Ibuprofen, or anti-inflammatory meds more than once a week?
(Y) ___ (N) ___ If yes, please explain ____

List all medications you are taking (prescription and over the counter): _______________________
____

Do you take oral anti-coagulant (blood thinning) medication? (Y)___ (N) ___ Specify: ____________

Have you had any cosmetic procedures I the past? Please list with dates: ________________________

Please list all surgeries or hospitalizations with dates: _____________________________________

Have you ever had any of the following (please circle):

Asthma	Arthritis	Anemia	Autoimmune Disorder	Blood Disorder
Chest Pain	Clotting Disorder	Diabetes	Depression	Easy Bruisability
Excessive Scarring	Excessive Bleeding	Heart Attack	Heart Valve Disease	Heart Failure
Thyroid Disorder	Hepatitis	High Blood Pressure	HIV	Hormonal Problems
Irregular Heart Beat	Intestinal Problems	Impaired Circulation	Impaired Skin Sensation	Keloids (scars)
Kidney Disease	Liver Disease	Lung Disease	Multiple Sclerosis	Muscular Dystrophy
Pregnancy	Raynaud's Disease	Rheumatic Fever	Seizures	Shortness of breath
MVP	Migraines	Open infected wound	Paroxysmal Cold Hemoglobinuria	
Skin Cancer	Stomach problems	Stroke	Heart Valve Replacement	

Cancer: (Please list type)____

To the best of my knowledge, the information above is true and accurate.

Patient Signature______________________________________ **Date:** _________________

Provider Signature____________________________________ **Date:** _________________