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__

E-Mail Address _____

Occupation _____ Employer _____

Emergency Contact _____ Relation _____ Phone (____) _____

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) _____

Age:____ Current Weight: ____lbs. Height: _____ Office Use BMI: _____

HEALTH INFORMATION

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

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: _____
_____

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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)_____

Do you have an interest in learning more about our weight management program? ? (Y) ___ (N) ___
If yes, what interests you?_____
_____

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

Patient Signature_____ Date: _____

Provider Signature_____ Date: _____