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 ___ Facebook ___ Twitter ___ Google ___

Friend______________________________ 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: ___________________________

____

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

____

NorCal Liposculpture
Dr. Jack Friedlander

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 Aspirin, 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	Easily Bruise
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:** _______________