Cosmetic Surgery & Aesthetic Consultation Form

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SchillingMedicalSpa.com

Patient ID: ←(FOR OFFICE USE) **Today's Date:**

Patient Name: ______________________ **DOB:** __________ **Social Security #:** __________

Address: ______________________

____

EMERGENCY CONTACT Name: ______________________

EMERGENCY CONTACT Phone: ______________________

Relationship: ______________________

Mailing Address (if different): ______________________

____

Home: __________

Cell: __________ CHECK PREFERRED

Work: __________ ←CONTACT NUMBER

Employer: ______________________

Occupation: ______________________

Email Address: ______________________

How did you hear about us? ______________________ **If a friend, name?** ______________________

Please tell us what you would like more information about:

Facials - Facial Services	Rosacea	Laser Skin Tightening/Anti-Aging	Facial Fat Grafting
Chemical Peels	Microdermabrasion	Laser Hair Reduction	Buttocks Enhancement
Home Skin Care Products	Neurotoxins (e.g. Botox, Xeomin)	Laser Vein Treatment	Breast Augmentation
Hyper-Pigmentation	Fillers (e.g. Juvéderm, Sculptra...)	Liposuction	PDO Threads
Micro-needling	Laser Stretchmark Reduction	Lipo-Abdominoplasty (Tummy Tuck)	Kybella

Please check all that apply:

Breast-feeding	Chronic Pain	Fatigue	Numbness	Clotting Disorders	Liver Disease	Blood Transfusion
Arthritis	Diabetes	Fibromyalgia	Sinus Problems	High Cholesterol	Intestinal Problems	Seizures
Anemia	Depression	Heart Disease	Smoker	High Blood Pressure	Gall Bladder Problems	NO KNOWN Medical Problems
Asthma	Edema	HIV / Aids	Spinal Problems	Tuberculosis	Kidney or Bladder Problems	
Cancer	Epilepsy	Insomnia	Varicose Veins	Thyroid Problems	Hepatitis (Type__)	

MEDICAL HISTORY

Question			
Have you ever had <u>any</u> kind of cosmetic surgery (e.g. Liposuction/Face/Body)?	NO	YES	If yes, specify: ______
Have you ever had mesotherapy or lipo-dissolve?	NO	YES	If yes, specify: ______
Do you have any allergies?	NO	YES	If yes, specify: ______
Are you currently using any oral medications?	NO	YES	If yes, specify: ______
Do you routinely take herbal supplements?	NO	YES	If yes, specify: ______
Are you taking anti-depressant or anxiety medication?	NO	YES	If yes, specify: ______
List any medications you are presently taking: ______			
Are you sensitive to LATEX?	NO	YES	
Are you currently pregnant / thinking in near future/ or breast-feeding?	NO	YES	If yes, specify: ______
If, applicable, when was your last menstrual period? ______			
Do you use birth control pills?	NO	YES	If yes, specify:
What body area is your concern? ______			

List ANY operation, surgery, or serious illness that have required hospitalization:

Month/ Year	Operation or Illness	Complications (any)?

SIGNATURE

I have listed all known medical/physical conditions, if I decide to proceed with surgery, I know I must fill out a complete medical history form. I confirm to the best of my knowledge that the answers I have given are correct and, that I have not withheld any information that may be relevant to my consultation.

______________________ ______________________

Signature Date today

OFFICE USE ONLY: CURRENT WEIGHT: HEIGHT:

ABDOMINAL GIRTH: BMI:

NOTES: