# Liposuction Consultation Form

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| Patient Name: |
| Date of Birth: |
| Phone Number: |
| E-Mail: |
| Preferred Method of Contact: text<br>(phone call, text or email) |
| Street Address: |
| City, State, Zip Code: |
| How did you hear about our facility?: |
| Have you had previous consultations in regards to this procedure? |
| Height:<br>Weight:<br>BMI:<br>(STAFF WILL CALCULATE) |

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| What areas are you hoping to treat with liposuction? |
| Are you looking to add on the Renuvion skin tightening as well? |
| Is a fat transfer something you are wanting to add on? (please specify to the breast or the buttocks) |
| By when are you looking to have the procedure done? |
| Please list any allergies you have:<br>What medications are you currently taking?<br>(include all OTC medications, herbal Vitamins supplements and vitamins) |
| Women: Are you actively trying to conceive? (Get pregnant) |
| Have you ever been diagnosed with any mental health disorders? |

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| Have you done CoolSculpting/ WarmSculpting?<br>If yes, please specify which. |
| Include any previous surgeries, cosmetic procedures<br>and routine, or hospitalizations<br>with dates (including injectables): |
| Do you smoke? If so, how frequently: |
| Do you drink alcohol? If so, how frequently: |
| Do you exercise? If so, specify how frequently: |
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| Review of Systems: (please check off any of the following that you have or previously had) | ( ) Anemia<br>( ) Asthma<br>( ) Blood disorders<br>( ) Cancer<br>( ) Chest pain<br>( ) Chronic lung problems<br>( ) Diabetes<br>( ) Difficulty walking two blocks<br>( ) Easy bruising<br>( ) Eye diseases<br>( ) Heart attacks<br>( ) Heart murmurs<br>( ) Heart palpitations<br>( ) High blood pressure<br>( ) Irregular heartbeat<br>( ) Kidney problems<br>( ) Problems with scarring/keloids<br>( ) Prolonged bleeding with cuts<br>( ) Rheumatic fever<br>( ) Skin disorder<br>( ) Swelling of the ankles<br>( ) Thyroid issues<br>( ) Ulcer/heartburn |
| Do you have a history of HIV or Hepatitis? | |
| Do you have any other serious illnesses? If so please explain. | |
| Have you had any adverse reactions to local anesthesia, lidocaine, epinephrine, or nitrous oxide? | |
| Covid-19 History: Have you ever had a positive COVID-19 test result? If yes, please list when: | |

Have you ever received the COVID-19 Vaccine? If yes,
when did you receive the 1st dose?
When did you receive the 2nd dose?

Signature: Initials: Date:

Witness: Provider: