



# BE SCULPTURED

## ***PERSONAL / MEDICAL DETAILS- please complete both sides***

Name:.....Sex: M F Date.....

Address: .....Suburb:.....Postcode: .....

Date of Birth: .....Your Occupation:.....

Telephone: (H) .....(W) .....(Mobile).....  
Please underline preferred daytime number

Personal Email address.....

Medicare No:..... Reference number on card (eg,1, 2 or 3).....Expiry Date:.....

Your Family Doctor: ..... Contact details:.....

### **GENERAL MEDICAL HISTORY**

Height:.....cm Weight:.....kg BMI: .....(if known)

Do you have any allergies (medicines, foods, pollens etc)? Yes..... No.....  
If so, please list them and describe your reaction (eg rash, itching, shortness of breath etc)

Are you presently taking any medication (including prescription and / or non-prescription (over-the-counter medicines such as aspirin / vitamins)? If so, please list them:-

Do you smoke? Yes..... No..... If so, how many per day.....

Do you drink alcoholic beverages? Yes.....No..... If so, approximately how much.....

Are you taking hormones or birth control pills? Yes.....No..... If so, please list them.....

Do you have children? Yes.....No..... If so, how many.....

(Women) Do you intend to have more children? Yes.....No.....

(Women) Have you had any miscarriages that may have been caused by clotting disorder? Yes.....No.....

### **PHYSICAL HISTORY**

Do you suffer from any medical conditions? Yes.....No..... Please list them:.....

Are you presently under the care of a doctor? Yes.....No..... If so, for what illness / purpose?.....

Do you enjoy good health? Yes.....No.....

#### **Have you OR have you ever had any of the following:-**

Heart disease or angina Yes.....No..... Raised blood pressure Yes.....No.....

Anaemia Yes.....No..... Thyroid problem / disease Yes.....No.....

Skin Cancer Yes.....No..... Asthma or lung problems Yes.....No.....

Any complications with previous surgery Yes.....No..... Kidney problems / disease Yes.....No.....

Previous back injury or nerve injuries Yes.....No..... A tendency to scar easily(keloid) Yes.....No.....

Fainting with medical procedures	Yes.....No.....	Previous blood transfusions	Yes.....No.....
Blood clots in legs or lungs, or leg swelling	Yes.....No.....	Bleeding disorder	Yes.....No.....
Any reaction to local anaesthetics or iodine	Yes.....No.....	Arthritis	Yes.....No.....
Psychiatric or psychological disorders	Yes.....No.....	Liver disease, jaundice or hepatitis	Yes.....No.....
Body Dysmorphic Disorder (BDD)	Yes.....No.....	Marked bruising following surgery	Yes.....No.....
Gastro-oesophageal reflux	Yes.....No.....	Hepatitis	Yes.....No.....
Sleep apnoea	Yes.....No.....	Diabetes / Hypoglycaemia	Yes.....No.....
Gastric sleeve / gastric banding operations	Yes.....No.....	Dark stains after injury or surgery	Yes.....No.....
Reaction from anaesthetic or sedative drugs	Yes.....No.....	HIV positive blood result	Yes.....No.....
(Women) Are you pregnant or planning pregnancy in the next few months or breast feeding			Yes.....No.....
Other medical problems.....			

### ***LIPOSCULPTURE / COSMETIC SURGERY QUESTIONNAIRE***

Have you had any previous liposuction or cosmetic surgery? Yes.....No.....

If so, what has been performed and when? .....

Were there any complications?.....

What is your motivation and expectations of cosmetic surgery?.....

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Have you been declined cosmetic surgery by another practitioner? Yes..... No.....

If so, why?.....

**\*A Body Dysmorphic Disorder (BDD) screening questionnaire is required by the medical board for anyone considering cosmetic surgery. If you choose not to complete it, cosmetic surgery cannot be provided.**

What was your maximum weight and when?.....

Have you gained weight recently? Yes.....No.....

If so, how much?.....

Have you lost weight recently? Yes..... No.....

If so, how much?.....

Do you intend to lose weight in the near future? Yes.....No.....

(Women) What is your present dress size?..... Bra Size?.....

What types of exercise do you do, how much and how often?.....

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What areas of your body do you request liposculpture?.....

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What are your major areas of concern?.....

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Do you have any specific questions?.....