BE SCULPTURED

PERSONAL / MEDICAL DETAILS- please complete both sides

Name:..…….... Age..... 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……
Gastro-oesophageal reflux	Yes……No….....	Dark stains after injury or surgery	Yes……No……
Sleep apnoea	Yes……No….....	HIV positive blood result	Yes……No……
Gastric sleeve / gastric banding operations	Yes……No.....	Marked bruising following surgery	Yes.....No.....
Reaction from anaesthetic or sedative drugs	Yes.....No.....	Diabetes / Hypoglycaemia	Yes……No….....

(Women) Are you pregnant or planning pregnancy in the next few months or breast feeding Yes……No……

Other medical problems…….

Interest in having your fat (stem cells) reinjected into your joints for arthritis? Yes.....No.....

Interest in having your fat (stem cells) reinjected into your face as volume replacement and rejuvenation? Yes.....No.....

Interest in having your fat (stem cells) harvested and saved (banked) for possible future health problems? Yes.....No.....

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?.....

.....

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?…….....

……

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

……

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