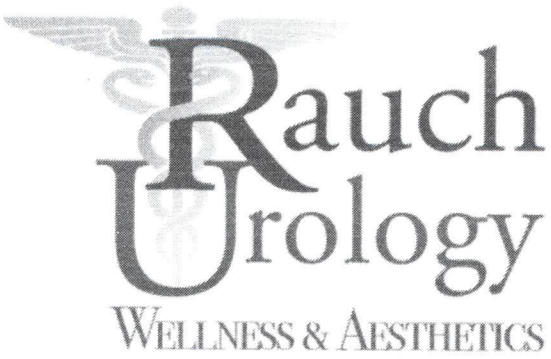


NAME:_____ D.O.B _____DATE:_____

CELL PHONE #_____CARRIER: AT&T/ VERIZON/ SPRINT/ T-MOBILE

OTHER (PLEASE SPECIFY)_____

EMAIL:_____

ALLERGIES:_____

CURRENT MEDICATIONS

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

NON-PRESCRITION/ VITAMINS/ OVER THE COUNTER MEDICATIONS

| Medication/ Vitamin | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

REASON FOR CONSULTATION

- CoolSculpting

- hCG Diet
- PRP for Urinary Leakage
- PRP for Erectile Dysfunction
- PRP for Hair Loss
- Botox/ Fillers
- Laser Hair Removal
- Vampire facial

## SOCIAL HISTORY

- Current Smoker
- Never a Smoker
- Former Smoker

Do you drink alcohol?

- Yes _____ Social _____Light _____Moderate _____ Excessive
- Not Anymore
- Never Drank

How many caffeinated beverages do you consume daily? _____

## MEDICAL/ SURGICAL HISTORY

What surgeries have you had? (Please include Aesthetic procedures)

_____

_____

_____

Please check all of the following that apply:

- Prostate Cancer
- Kidney Cancer
- Other Cancer
- Diabetes
- Renal failure
- Kidney Stones
- Ulcer
- Arthritis
- Asthma
- COPD
- Blood Clot
- Currently Pregnant
- Currently Breast Feeding
- CHF
- MI
- Cardiac Problems
- Arrhythmia
- Hyperlipidemia
- High Blood Pressure
- Diverticulitis
- Seizure
- Depression
- Hepatitis
- Anemia
- Thyroid Disease
- Stroke

## FAMILY HISTORY

- Cancer
- Heart Disease
- Diabetes
- Stroke
- High Blood Pressure

**FOR COOLSCULPTING AND hCG CONSULTS SEE PAGE 3**

## COOLSCULPTING

Do you have any of the following?

Cryoglobuinemia or paroxysmal cold hemoglobinuria Yes/ No
Known sensitivity to cold such as cold urticarial or Raynaud's disease Yes/ No
Impaired peripheral circulation in the area to be treated Yes/ No
Neuropathic disorders such as post-herpetic neuralgia or diabetic neuropathy Yes/ No
Impaired skin sensation Yes/ No
Open or infected wounds Yes/ No
Bleeding disorders or concomitant use of blood thinners Yes/ No
Recent surgery or scar tissue in the area to be treated Yes/ No
A hernia of history of hernia in the area to be treated or adjacent to treatment site Yes/ No
Skin conditions such as eczema, dermatitis, or rashes Yes/ No
Pregnancy or lactation Yes/ No
Any active implanted devices such as pacemakers and defibrillators Yes/ No
*****Pictures will be obtained for medical records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed. Initial:_____**

## hCG

Do you have any of the following?

Deep Vein Thrombosis or a history of one Yes/ No
Polycystic Ovary Disease Yes/ No
Pituitary Tumor Yes/ No
Ovarian Tumor Yes/ No
Prostate Cancer Yes/ No
Breast Cancer Yes/ No
IUD for birth control
Blood clots in the legs or lungs Yes/ No