PATIENT INFORMATION SHEET- LipoClinic Dr. Heck

Title: Mrs., Ms.
(please circle) Mr., Dr., other: _____ Date of Birth: _____Sex: ___M___F

Name: _____

Street: _____City: _____

State: _____Zip: _____Social Security #:_____

Phone Numbers:

Home: _____Cell: _____Work: _____Ext: ___

Which phone number is the best one to reach you? _____

Primary Care
Physician: _____City/Town: _____Phone#: _____

Pharmacy Name: _____Pharmacy Tel#: _____

Emergency Contact: _____Tel#: _____

Email: _____
*by giving us your email address I authorize Dr. Heck to Blind copy my address onto mass emails from the Lipedema Center. My address will not be sold or distributed.

REFFERED BY:
Physician: _____ Friend/Family: _____Website: _____
Yellow Pages Book: _____Boston Magazine: _____ BMC Hospital Website: _____
Google Search: _____Yahoo Search: _____Other Search Engine: _____
Other: _____

TREATMENT INFORMATION
What medications are you presently taking (i.e. birth control, hormones, blood pressure, heart, cortisone, aspirin, blood thinners, tranquilizers, antidepressants, etc.)?

_____

Are you allergic to any oral or topical medications? If so, what kind? Yes_____No_____

_____
List all serious illness, medical conditions, and past surgeries:

_____

Please answer:

Yes or No

___ ___ Have you ever had any cosmetic procedure? Explain_____
___ ___Was the procedure successful?
Please explain_____
___ ___Have you ever had laser treatments?
___ ___Do you have lupus or any other collagen disorder?
___ ___Do you have any immune deficiency?
___ ___Have you had electrolysis treatments?
___ ___Do you have scleroderma or burns in the area to be treated?
___ ___Have you taken the drug Accutane within the last two years?
___ ___Do you have any heart problems (i.e. heart attack, chest pain, angina, etc.)?
___ ___Are you pregnant, breast feeding, or planning a pregnancy soon?
___ ___Have you ever had any seizure disorder?
___ ___Do you have a history of cold sores?
___ ___Have you ever seen, or been advise to see a psychiatrist or mental professional?

Do you have a history (check all that apply)?

___Bleeding disorder___Celoid scars___Poor healer
___Hyperpigmentation (darkening of the skin) ___Large Hypertrophic scars

Describe your skin reaction when exposed to the sun:

___Always burns, never tans
___Sometimes burns, tans with difficulty
___Rarely burns, tans with ease

What would you like treated by liposuction?

___Lower legs
___Tighs
___Buttocks
___Arms
___Other:_____

Patient's Signature: _____Date:_____

PHOTOGRAPH CONSENT

We will routinely take photographs to document treatment results. Occasionally, we might use the images for teaching or scientific publications. We will not use these photos for advertising without contacting you for permission as well as your signature on a separate written consent.

I agree to have photos taken for the reason above: _____
Patient's signature and date

Exclusions (if any):_____