

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate medical treatment, please complete the following questionnaire as accurate as possible. All information is strictly confidential.

Personal History

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Emergency Contact Name & Phone _____

How were you referred to us?

___ El Paso Times

___ TV-Channel 9

___ Ft. Bliss Monitor

___ TV-Televisa

___ The Scene

___ TV-Telemundo

___ TV y Mas Magazine

___ Internet

___ Phonebook

___ Word of Mouth

___ TV-Cable

___ Other: _____

Medical History

Are you currently under the care of a physician? ___ Yes ___ No

If yes, what for: _____

Do you have any of the following medical conditions? Check all that apply.

___ Cancer ___ Diabetes ___ High Blood Pressure ___ Herpes ___ Arthritis

___ Frequent Cold Sores ___ HIV/AIDS ___ Keloid Scarring ___ Skin Disease/Skin Lesions

___ Seizure Disorder ___ Hepatitis ___ Hormone Imbalance ___ Thyroid Imbalance

___ Blood Clotting Abnormalities ___ Any Active Infection

Do you have any other health problems or medical conditions? If so, please list: _____

Have you ever had an allergic reaction to any of the following? If so, please explain the reaction you experienced. Food Latex Aspirin Lidocaine Keflex

Others: _____

Have you ever smoked cigarettes? YES NO

If so, when was the last time you smoked? _____

Medications

What oral medications are you presently taking? _____

Are you on any mood altering or anti-depression medication? _____

Do you use any herbal supplements regularly? If so, which ones? _____

History

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe: _____

For Female Patients.

Are you pregnant or trying to become pregnant? Yes No

Are you using contraception? Yes No

I certify that ALL of the preceding information is true and correct. I am aware that it is my responsibility to inform the office personel, medical assistant or doctor of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____

Date _____



Photo Consent

This consent form authorizes Dr. Jabour & Southwest Liposculpture to use these photographs for marketing, medical education, teaching or research. Under no such circumstances will any publications or material bear your name. Your refusal to consent the use of these photographs for marketing, medical education, teaching or research will in no way influences your treatment.

I _____, understand the photographs taken of me shall be used for medical records and if in the judgment of the medical health care professional, marketing, medical research, education or science. Any photographs and/or information relating to my case may be published and republished, either separately or in conjunction with each other, in professional journals or proper in the interest of marketing, medical education, knowledge or research.

I waive the rights that I may have to any claims for payment of royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless the clinic, staff and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the following limitation:
Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name unless voluntarily disclosed by me.

Signature of Patient

Printed Name

Signature of Witness

Date

OR

I _____, only consent for my pictures to be used for medical purposes.
They are only for my file and to be kept to review and monitor my progress.

Signature of Patient

Printed Name

Signature of Witness

Date