

Zerona 6 LipoLaser/ Laser-Assisted Liposuction

Patient Targeted Health History

Name: _____ Date: _____

Cell phone: _____ Email: _____

Date of Birth: _____ Age: _____ Gender: M F O: _____

Occupation: _____

Please complete this Targeted Health History:

1. Body Mass Index (BMI) or Body Fat % 30kg/m2 Yes No

2. Diabetic diagnosis: insulin or oral hypoglycemic medications Yes No

3. Any diagnosis of cardiovascular disease, heart surgeries, heart implants Yes No

4. Any diagnosis of kidney disease, liver disease or dialysis therapy Yes No

5. Alcohol consumption (more than 21 alcohol drinks per week) Yes No

6. Smoking, vaping, chewing, nicotine patch Yes No

7. Surgery: liposuction, abdominoplasty, stomach stapling, lap band, cryo, etc. Yes No

Was it successful to any extent? _____

8. Rx or OTC medications to affect weight loss, slimming, increase metabolism, thyroid Yes No

List: _____

9. Any medical condition known to cause weight increase, bloating, or swelling Yes No

Explain: _____

10. Any diagnosis of auto-immunity, poor circulation, varicose veins, high blood pressure Yes No

Explain: _____

11. Any diagnosis of irritable bowel syndrome, Crohn's, diverticulitis, bladder problems Yes No

Explain: _____

12. Any active infection, lesion, wounds at the areas of laser treatment Yes No

13. Recent scarring within the past 2 years in the treatment area Yes No

14. Pregnant, breast feeding, or planning pregnancy prior to the end of treatment Yes No

Patient's signature: _____