PATIENT INFORMATION MEDICAL HISTORY
CELINE AESTHETIC MEDICINE AND LASER LIPOPLASTY

Name:______________________________DOB______________AGE________

Address:____

____

e-mail address;____

Phone :
Home_______________Cell_________________Work_______________

Employer:________________________________Occupation:_____________

Emergency Contact:__________________________Relationship:___________

Phone:
Home:___________________ Cell:________________Work:_____________

Health History

Medication (prescription and over the counter: vitamins, herbal medications)

____
____
____

Allergies:____
____

Surgeries:
Dates:____
____
____

Have a history of?

__Heart Disease
__Excessive Bleeding
__High Blood Pressure
__ Other

___Mental Disease
____Auto Immune disorder
____Liver Disease

___Neuro-muscular disease
___Diabetes
___Cold Sores/Fever Blisters

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Are you? Pregnant_______________ _Nursing____________
Do you? Smoke________ Drink Alcohol___________Amount per day___________

The above information is true and accurate to the best of my knowledge.

______________________________________ ____________________
Patient Signature Date