ZEPH COSMETIC SURGERY

COOLSCULPTING® TREATMENT QUESTIONNAIRE FORM

Name_____Birthdate_____Today's Date_____

Address: Home_____(_____)_____
Street City State Zip Phone

Business_____(_____)_____
Street City State Zip Phone

Email Address: _____Cellular Number:(_____)_____

How were you referred to our office?_____

Do you have any significant medical history?_____

NO YES Are you taking any prescription or over the counter medications? (How often?)

List them_____

NO YES Are you allergic to any medications?

List them_____

List any previous surgeries: _____

NO YES Have you had any laparoscopy surgery to the abdomen or Cesarean section births?
If so, list surgery and date(s):

_____

Depending on the length of time from your surgery, you may be required to get a physician clearance for Coolsculpting.

Do you have any of the following:

NO YES Cryoglobulinemia or paroxysmal cold hemoglobinuria?
NO YES Known sensitivity to cold such as cold urticarial or Raynaud's disease?
NO YES Impaired peripheral circulation in the area to be treated?
NO YES Neuropathic disorders such as post-herpetic neuralgia or diabetic neuropathy?
NO YES Impaired skin sensations?
NO YES Open or infected wounds?
NO YES Bleeding disorders or concomitant use of blood thinners?
NO YES Recent surgery or scar tissue in the area to be treated?
NO YES A hernia or history of hernia in the area to be treated or adjacent to treatment site?
NO YES Skin conditions such as eczema, dermatitis or rashes?
NO YES Pregnancy or lactation?
NO YES Any active implanted devices such as pacemakers and defibrillators?

SIGNATURE OF PATIENT_____DATE_____